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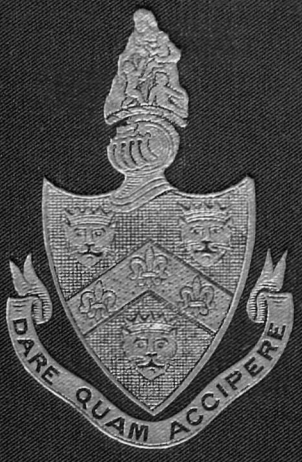

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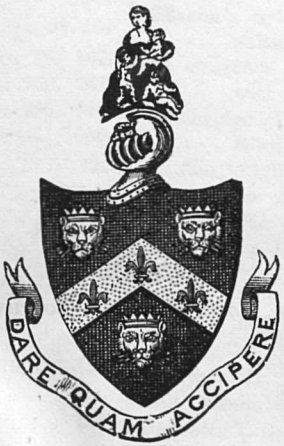

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"Hullo, Thirteen! What's that you're taking 'em?"
"Well, it was meant for a present of rare and refreshing fruit"; but the bottom seems to have fallen out of the blessed thing!"

GUY'S HOSPITAL GAZETTE.

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Passim.

WITH sighs of mingled regret and relief the normal duties of hospital life have been resumed. Festivities are finished, and relaxations have given place once more to necessary routine. From the first note of the Niggers to the last crackle of the bonfire, Christmas week has passed without hitch or hindrance, and in passing has left its customary trail of vivid memories. To select the particular points of excellence from a series of entertainments, which were all excellent, is no easy task. Suffice it to say that in the performances of the Niggers, in the Ward Concerts, and in the Residents' Theatricals, all tastes were catered for and duly gratified. The Niggers were, as usual, said to be "better than last year," and the spectacle afforded by their costumes was only rivalled by the quaint variety of vocal talent hailing from unexpected quarters. Among the patients and the ward-maids, and "quietly" among the more classically-minded also, the gentleman who sang of "the Spaniard who blighted his life," was perhaps the most popular turn; but others ran him very close, and one and all are to be congratulated and thanked on behalf of those numerous audiences whose appreciative laughter they evoked by their untiring endeavours.

Thanks, too, are due to the multitude of volunteers from the outside world, many of them famous and most of them busy people, who so generously contributed towards the fund of enjoyment during the course of the week.

Our artists, too, must not be forgotten. Mr. Wingent, in spite of his enforced absence, was with us in spirit on the frontispiece of the programme of the Residents' Play. Mr. Stanley Cock provided food for amusement and speculation on the inner pages of the same production, while numerous posters by other artists as usual adorned the Colonnade.

The Nurses' Entertainment was in all respects excellent, and the producers and performers of "The Return of the Wanderers" have our best congratulations.

AN account of the Residents' Theatricals will be found elsewhere. The production was an admirable one and well performed. As a type of topical play it could scarcely have been surpassed, for it succeeded in being "topical," without failing to amuse, and without giving unnecessary offence.

The purpose of the piece, and of all such pieces, was neatly put forward in the verses addressed to the Staff, included in each copy of the programme, and of which we quote the final verse below:—

> In motley clad, with Folly for a steed
> We'll tilt at all the foibles of the day,
> And bid all you who listen to give heed
> And note the morals pointed in our play.
> Our humour rides alone, and from her train
> Is banished malice, for we do but chaff,
> And if we wound, then ours is the pain
> Whose only object was to make you laugh.

How far the play will be successful in its propagandist efforts it is too early to say. The

morals pointed were all sufficiently obvious, and the enthusiasm with which the various sallies, directed at the more conservative elements in hospital management, were received, augurs well for the success of any progressive movement that should be instituted within our walls.

THE Landon Christmas Tea was as successful and as noisy as ever. It was magnificently organised, and the workers in connection with it must have been amply repaid by the results of their labours, and by the thought that six or seven hundred, at least, of the children who dwell in the Borough, went home on Christmas night with full stomachs and happy hearts. One of the richest features of this entertainment is the great, spontaneous outburst of song, which is invariably raised by the whole of the youthful assembly at the conclusion of the tea. Is it a primitive means of demonstrating appreciation —a kind of thank-offering for the feast? Or is it merely the reaction of satisfaction that follows on the realised dream of an unstinted meal? Whatever its purpose or the stimulus behind it, and however deafening it be, it is a sound well worth the hearing.

THE termination of Christmas Celebrations this year is, however, marked by one really sorrowful feature, for it coincides with the conclusion of Mr. Clive Carey's immediate connection with the Hospital. It is just over three years since Mr. Carey first made his appearance at Guy's, and from the moment of his entry became the friend of all who knew him. His activities in many spheres have won for him wide-spread appreciation. The Musical Society would have died without him; with his aid it survived, and was able to show its gratitude by becoming once more a flourishing institution. The Chapel is equally indebted to him for his devoted services; it was for the Chapel primarily that he was selected as organist, and the Chapel has always been his chief concern.

The organ and choir bereft of Carey is a melancholy thought, while Christmas without Carey is scarcely conceivable. He has been the heart and soul of the Niggers and of the Residents' Theatricals; as leading lady in the latter he has achieved a series of successes by his first-class acting and singing, and his really delightful portrayal of feminine charms and characteristics will long be remembered. In the Ward Concerts he has given of his best, and he has always and everywhere volunteered ungrudgingly for any task which might require his aid.

His excellence as a musician and his fame as a songster are only surpassed by his general charm and good-fellowship. It is the combination of all these attributes, we suppose, that has resulted in further pressing claims upon his time elsewhere, and in his consequent resignation. He will take with him wherever he goes the good wishes of scores of men and women at Guy's, and will always find a warm welcome waiting should fortune turn his footsteps to our doors.

WE have received no answer to the letter from Sister Out-Patients which appeared in our last issue, and, in view of the indubitable evidence which prompted her timely appeal for reforms, an answer could scarcely, perhaps, have been expected. The silence, we take it, spells admission of the fault. Moreover, we understand that the communication has already had some effect, and that her suggestions are being partially adopted in some of the Out-Patient Departments. Pressure of work, absent-mindedness, and the desire to avoid awkward or disagreeable explanations have, we presume, been the main causes of neglect in the past, but the old spirit of conservatism, and "the self-satisfaction" that "has them by the throat," probably also played their part. In the future, even if our suggested scheme of printed slips is never adopted, we hope that it will at any rate become the rule to inform patients affected with venereal disorders that they are suffering from "a contagious disease," and to advise them as to the necessity of undergoing full periods of treatment. It is surely quite possible to take such steps without running the risk of becoming involved in family or legal disputes, and in any case the

alternative risk is frequently a more serious one. No one in future, we hope, will fail to warn Nurses who have been instructed to dress or otherwise deal with cases coming under this category.

THE British Medical Association having adopted, wisely or unwisely, a trade union policy, is now greatly perturbed on encountering some of the difficulties and obstacles, which of necessity, lie in the path of trade-unionism. In recent industrial disturbances those men who refused to join the bulk of their particular union in the adoption of a "strike" policy, were hailed by a large section of those classes, from which medical men are principally drawn, as loyalists and upholders of the dignity of labour. In the present medical dispute those who have separated themselves (after obtaining certain of the concessions demanded) from the body which continued to demand all concessions and in effect to remain "on strike," are promptly accused of disloyalty and lack of regard for the dignity of the profession. It is a strange paradox, and we cannot help feeling that solidarity is being jeopardised rather by those who persist in going "the whole hog" than by those who, whether from a sense of duty towards the insured persons, or from necessity, or from previous conviction, have decided to work the Act.

However expedient it may be to try and make a pledge binding, it must be obvious that change of opinion and the awakening of other than selfish considerations are always likely contingencies and are, morally, entirely justifiable.

To demand that intelligent men shall perpetually conform to a policy arranged and interpreted by a body who have been constituted their leaders is unreasonable, and more particularly so when the interests concerned are not only the interests of their own faction, but also those of the community at large.

In view of the fact that the Act must undergo drastic amendment after it has been in working for a very short while, and of the fact that a very large number of doctors have already agreed to have their names put upon the panels, surely the wisest course, and certainly the most honourable course from the point of view of the community, is for the profession to decide with the best grace possible to work the Act for a definite period.

THE Dental Society's Dinner has been unavoidably postponed, and it will now be held at the Trocadero Restaurant on Saturday, February 15th. Mr. Ernest B. Dowsett will occupy the chair. On the afternoon of the same day the new Dental School Buildings will be open for inspection from 3 p.m. till 5 p.m. Clinical cases of interest will be shown, demonstrations will be given, and there will be a display of mechanical work. Tea will be served during the afternoon. Applications for dinner tickets, price 7s. 6d., should be made as early as possible to the Hon. Sec., Mr. Guy Neely.

THE following house appointments have been made:—House-Physicians, Mr. A. C. Jepson (Dr. Pitt), Mr. W. E. S. Digby (Dr. Shaw). House-Surgeons, Mr. V. Glendining (Mr. Lane), Mr. G. Foster-Smith (Mr. Dunn). Out-Patient Officers, Mr. C. A. R. Gatley, Mr. W. S. George, Mr. J. M. Jarvie, Mr. L. Milton. Assistant House-Surgeons, Mr. C. Aldis (Mr. Fagge), Mr. G. S. Miller (Mr. Rowlands), Mr. J. M. Joly (Mr. Turner), Mr. T. P. Cole (Mr. Hughes), Mr. T. I. Bennett (Mr. Davies-Colley). Obstetric Resident, Mr. A. J. McNair. Dental House-Surgeons, Mr. L. P. Harris, Mr. F. W. Lawrence, Mr. M. Schneider. Assistant Dental House-Surgeons, Mr. A. J. Barber, Mr. C. Glover, Mr. C. H. Edwards.

MR. H. W. BARBER has been elected to the Arthur Durham Travelling Studentship. He has our very hearty congratulations.

THE present issue of the GAZETTE opens a new volume, the twenty-seventh. An index and title pages for last year's volume will shortly be prepared, and readers who wish to have their sets bound should send them to the Librarian. The bindings are in two shades of blue, with the Hospital Arms in gold.

J. A. R.

Historical Notes of Guy's.

BY FREDERICK TAYLOR, M.D.

I. Wax Models.

It has been one of the articles of faith of the Guy's man that the wax models in the Museum are the best of their kind in the world, but it was only recently I found that this was acknowledged in a standard work not concerned with any branch of medical science. In the "Curiosities of Literature," by Isaac Disraeli, there is an article on "Waxwork" which opens with a reference to a series of anatomical sculptures in coloured wax, projected by the Grand Duke of Tuscany under the direction of Fontana. Twenty apartments were said to be filled with these "curious imitations," and they represented "many transient phenomena of disease" as well as the healthy anatomical structures. To this there is a footnote as follows:—

"The finest collection at present is in Guy's Hospital, Southwark; they are the work of an artist especially trained there, who by long practice has become perfect, making a labour of love of a pursuit that would be disgustful to many."

Isaac Disraeli published the first volume of his Curiosities of Literature in 1791, a second volume in 1793, and others many years later. The article on waxwork is in the first series. The edition in which I find the above footnote is "a new edition, edited with memoirs and notes by his son, the Right Hon. B. Disraeli," in three volumes, George Routledge & Sons, 1865. We therefore owe the footnote to the great writer and statesman who subsequently became the Earl of Beaconsfield.

There have, of course, been many editions of the Curiosities of Literature, and by different publishers. One published in 1849 seems to be the first to which an introduction was supplied by Benjamin Disraeli, and that of 1865 the first to which "notes" were added. An edition by Warne & Co. in 1881 has the same introduction and footnotes, this time, of course, "by his son, the Earl of Beaconsfield."

In some other editions of the last fifty years the biographical memoir is by W. C. Taylor, LL.D., and there are no footnotes.

Mr. Joseph Towne, who made all the wax models in the Guy's Hospital Museum, was born in 1808, was attached to Guy's Hospital as modeller in 1826, and died in 1879. The museum contains the clever model of a skeleton, which he showed to the Treasurer, Mr. Harrison, at the time of his appointment. A memoir of him by our Senior Consulting Surgeon, Mr. Thomas Bryant, will be found in the Guy's Hospital Reports, vol. xli. By the year 1865 the great majority of Mr. Towne's models were already made, practically all the anatomical models, including the beautiful dissection of the arm and chest, which was shown at the second Great Exhibition in 1862; nearly all the models of skin diseases, and a great number of the pathological series.

The Italian models were obviously made in the latter half of the eighteenth century, as Fontana was born in 1730, and Isaac Disraeli knew of the models in 1791.

Change of Address.

Captain F. A. Barker, M.B., I.M.S., from Port Blair, Andamans, to Superintendent, Borstal Central and Female Jail, Lahore, Punjab, India.

C. H. Bradnam, L.D.S., from "Camber" to Trenton Lodge, 16, Eversley Road, Bexhill-on-Sea.

H. L. Eason, M.D., M.S., from 37, Queen Anne Street, W., to 62, Portland Place, W.

J. W. Emmet, L.R.C.P., M.R.C.S., from "Sandon," Sea Road, Bexhill-on-Sea, to "Spurborne," Summerdown Road, Eastbourne."

R. C. H. Francis, M.B., B.S., M.R.C.S., L.R.C.P., from 31, Glenthorn Road, West Jesmond, to Merton House, Ross, Herefordshire.

G. R. Hind, M.B., B.S., from Roxeth House, Stoke-on-Trent, to 20, Stamer Terrace, Stoke-on-Trent.

E. C. Hughes, M.C., F.R.C.S., from 26, St. Thomas's Street, S.E., to 37, Queen Anne Street, W.

A. E. Rowlett, L.D.S., from 67 to 165, London Road, Leicester.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

The Residents' Theatricals, Christmas, 1912.

From the Hospital point of view, by far the most interesting item of the Christmas festivities is the Residents' Theatricals. They represent the expenditure of much time and labour, many profound researches into the latest eccentricities of the Staff, and much talent on the part of those who are not necessarily born actors. This year everything proved entirely successful. The plot was ingenious, the dialogue crisp and witty, the lyrics, as was foretold in the verses printed with the programme, topical and trenchant, but without malice, whilst the stage management and acting were as good as we have ever seen at Guy's. E. G. Schlesinger and his plot-hatcher, G. Marshall, are greatly to be congratulated on the success of their play, whilst Mr. A. L. Gardner, as the producer of the delightful and catchy music of the piece, once more placed us all deeply in his debt. The caste of the play was as follows:—

"PROGRESS: OR, THE LIGHT THAT FAILED." *
Being a Harmless Hypnotic in Three Doses, exhibited by E. G. Schlesinger (despite the persistent and exasperating help of G. Marshall). Music by A. L. Gardner.

DRAMATIS PERSONÆ.

IMMORTALS.

Hippocrates ...	An Ancient "Nut" ...	A. H. Todd.
Galen ...	One of those Physicians (*sic*)	T. B. Heaton.
Celsus	A Surgeon ...	J. L. Symns.
Aræteus ...	A Bore ...	E. R. Hart.
Hermes ...	... ...	Mr. R. Stout.
Secretary ...	(With Pen) ...	F. G. Lloyd.
Progress ...	... ...	R. Montgomery.
Discontent ...	... ...	Clive Carey.

MORTALS.

A Sister ...	... ...	H. L. James.
A Probationer	... ...	P. Smith.
Another Probationer ...	...	E. R. Hart.
An H.-P. ...	... ...	F. G. Lloyd.
A Clinical ...	... ...	A. S. Roe.
A Dresser ...	... ...	R. Stout.
A Borough Mother	and From the Prince of Wales' (pub)	G. Marshall.

Wigs by Clarkson. Scenery by John Bull.
Moustache by R. Stout.

PROLOGUE.

Act I. ... ... Hades (or Hell).
This Act does not exactly represent any particular place in the Hospital.
Act II. ... ... Isolation Ward (Diphtheria) at Midnight.
Act III. (Scene I.) Hades.
(Scene II.) The Surgery (*not the same as Scene I.*).
Orchestra ... ... Mr. J. M. Jarvie.
Advertising Manager ... Mr. Stanley Cock.

**This does not refer to the new X-ray Department.*

A number of beds have been reserved in the Accident Wards for members of the audience. Other visitors needing help will be sent to the Infirmary.

The opening scene was placed in Hades (or Hell), and there we found a medical meeting in progress, *Hippocrates*, admirably impersonated by Mr. Todd, being in the chair. *Galen*, a somewhat pompous physician, skilfully interpreted by Mr. Heaton, holds forth on the virtues of his latest drug despite the obvious scepticism of his colleagues, whilst *Hippocrates* demonstrates later on that there is no novelty at all in his suggestions. *Aræteus* (Mr. Hart) follows with a poetic description of Pneumonia which, by the way, might prove useful to many a harrassed ward-clerk. Again, Hippocrates claims that nothing new has been stated and quotes his own aphorism.

"Every little rhonchus, whistling through the chest,
Makes the wise physician auscultate the rest."

Celsus, in which part Mr. Symns gave a clever and subtle representation of a well-known surgeon, declaims that what is wanted is "primary union" with a bias towards amputation, and there is much consequent disorder in the meeting. Suddenly *Hermes*, suitably represented by R. Stout in the costume of a Boy-Scout, appears, bearing copies of the "Hell Century," which he distributes. Each is eagerly scanned for news of the upper world and dismay is expressed at the stagnant condition of things especially as revealed by the latest accounts of Guy's. Drastic measures are required and it is decided forthwith to send two missionaries from Hades to Earth. *Progress* and *Discontent*, appropriately impersonated by a man and a woman respectively, are sent for and declare their intention of bringing about radical changes in the realms above, Guy's being selected for their first attack.

Before breaking up the meeting, however, Progress leads the ancient sages in a witty topical song of which perhaps the best verse was:

"Hertz, having tired of his Bismuth,
Which really was quite a good thing,
He turned from his duty, to love and to beauty,
And gave up his books for a ring.
He's learning to dance very nicely,
A thing that his partners will bless,
And he'll teach folk with tabes, the Glide that is Gabys'
And send the results to the Press.

Chorus—
If you want to know the way to do things,
Just ask Hertz.
If you want to hear the latest new things,
Just ask Hertz.
John Dunn is the only one left now to chaff,
And though married folks think it clever to laugh,
To me he's the wisest of all on the Staff,
Just ask Hertz!"

Act II. showed us Isolation Ward at midnight, and *Discontent*, now a fascinating nurse (as was inevitable, Mr. Clive Carey played this part to perfection), is watching over a case of diphtheria. *Progress* (in private life R. Montgomery) appears, and having apparently lived up to his name, announces that with bewildering rapidity he has been made R.S.O. The two concoct a not very

convincing plan of campaign to rouse up Guy's still further by insisting on Standing Orders being obeyed *literatim et verbatim*, trusting by the resulting chaos to make plain the flaws in the management of the Hospital. So far, so good, and *Progress* departs. Enter now a *Borough Mother*, superbly acted by G. Marshall, who divides her attention between spasmodic enquiries for her suffering little 'un, and a graphic monologue in the purest Bermondsey dialect on the ways and characteristics of the Staff. By means of, to the audience, vague jugglery on the part of *Discontent*, the baby becomes seriously ill, but by the Standing Orders Sister must first be fetched before anything more can be done. The Boro' mother fetches her, a novel proceeding, and *Sister* appears, charmingly represented by H. L. James in a most becoming "blue." Still much must be done 'ere the little 'un can be treated; the Clinical must be sent for, but it being after 10 p.m. he must obtain the permission of the H.P. before he can enter the Ward. These details of the Standing Orders having been carried out, at length the R.S.O. is found, and with marvellous dexterity worthy of his supernatural origin, puts all to rights, winning thereby the amazed applause of his colleagues, and, not least, the affectionate endearments of the Boro' mother.

Incidentally in the midst of these proceedings a clever song with a most catching chorus has been sung by *Discontent*, describing with painful accuracy the woes and troubles of a Sister.

The first scene in Act III. took us back to Hades, where for a brief space the inhabitants held forth in blank verse and gross darkness on the way in which their missionaries were faring on earth, and on the whole we gathered that all was well.

Scene II. showed us the Surgery, a helpful and necessary note on the programme explaining that we were not still in Hades, and we find that *Progress* has been revolutionising affairs at rather too rapid a pace. No longer are patients kept waiting, and the Boro' mother finds in this a real grievance, inasmuch as she has no chance to sit and chat pleasantly and melliflously with her friends about her spasms before her turn comes for treatment. A nurse (Oh! (P. Smith) who would have thought it of you!) almost swoons as she describes the changes which have come about in the O.-P. Department, and one after another the characters in the play tell with amazement, and even with disgust, of these reforms. It is too much of a good thing, and finally *Progress* by a dramatic and semi-hypnotic cure of the multitudinous pains of the Boro' mother so oversteps the bounds of the believable, that suspicion is thrown on his nature, and, *Discontent*, unkindly turning informer, he is revealed as an immortal and denizen of Hades. The climax has come and with it a warning declaration on the impossibility of progress at Guy's. *Progress*, by the aid of skillful stage management, vanishes and the play ends. This Act was further enlivened by a song declaiming the virtues of progression and the "ultra-modern-hustle-to-be-first."

We shall not attempt to comment in detail on the acting of the various performers. The classical parts of Sister, Nurse, Hospital Resident, and Boro' Inhabitant were all played with excellence. In the scenes in Hades there was much of real novelty, and the actors appreciated fully the histrionic possibilities of their parts, whilst the stage management of these scenes was admirable. Montgomery proved an able vocalist and made effective use of every point in his songs, whilst Clive Carey's song was, as always, all that could be desired.

The plot of the play, whilst somewhat light and occasionally lacking in effectiveness, especially towards the end, nevertheless afforded a satisfactory thread on which to string the topical satire, witticisms and parodies on which mainly depend the success of such a production.

Any account of the Theatricals would be grievously incomplete without grateful appreciation of the printed Programme, and the highest tribute must be paid to the art of Mr. Wingent on its cover, and Mr. Stanley Cock in his original "Spot the Staff" competition amongst its pages. Last, but not least, the self-effacing and meritorious work of Mr. J. M. Jarvie as the Orchestra, is to be recorded with gratitude.

On the first night the play was preceded by some excellent singing and recitations. Miss Katherine Dyer and Mr. G. Dunderdale were the vocalists, while Miss Nellie Sargent gave the recitations. Miss Katherine Dyer completely captivated her audience, and fully deserved the bouquet with which she was presented, and the prolonged applause.

On the second night Mr. G. Seabrooke, whose acquaintance we made last year, met with a great reception, and some delightful music was rendered by Mrs. Morrice (Piano); Miss Gardiner and Miss O. M. Hunt (1st Violins); Mrs. Harold Gardiner and Miss C. L. E. Pellue (2nd Violins); M. G. H. Hunt (Viola); and Mr. Harold Gardiner ('Cello).

On the last night Miss O. M. Hunt with the Violin, Mr. G. Seabrooke and Miss Ettie Gillett, with their singing, met with well-merited ovations. Warm thanks are due to all of these for their contributions towards the success of the three evenings.

The Nurses' Entertainment.

THE Nurses' Entertainment, held in the Home on Monday, December 30th, was certainly one of the best functions of the week. The visitors were received in the entrance-hall by the Matron, and were then ushered into the tastefully decorated sitting-room, where the principal performances of the evening took place. The orchestra led off with "Henry VIII. Dances," which were admirably rendered, and was followed by Nurse E. Hope with "A Japanese Love Song." The charm of the song was further enhanced by the accompanying tableau illustrating the words. With "Only an Orange Girl" Nurse E. M. Fletcher delighted her audience, but a large share of the

honour is also due to the performer of the picturesque tableau. A charming recitation entitled "Sh!" was given by Nurse Maughan, who succeeded in conveying the impression of puzzled childhood in a truly delightful fashion. The next item was a song, "May, June, July," sung by Nurse Tyler Cove, also accompanied by an exquisite and decorative tableau portraying the three summer months. An able pianoforte solo by Nurse C. Pearson was followed by "Caller Herrin'" sung by Nurse Dickson. One of the best of a series of tableaux, which were, perhaps, the happiest feature of the evening, constituted the setting. Nurses L. Wood, M. West, Gillet, and Maher contributed a part-song, "Braid the Raven Hair," and were ably supported on the stage by a Japanese tableau. A Caledonian song, "A Richt Guid Time," with a very fascinating setting by Nurse Tyler Cove, was rendered with feeling by Nurse Mackenzie; and with "Humoreske" the orchestra concluded the first part of the programme.

Then followed a clever piece of topical drama for which, we understand, Sister Lydia and Sister Gladys were jointly responsible, the latter also taking the part of producer and stage manager. We congratulate them both, and also the performers, and on behalf of the audience must thank them for a very entertaining production. The piece was entitled "The Return of the Wanderers," a Guy's Mystery Play, enacted by The Prologue, The Imp of Guy's, introducing Vienna, Mr. L. (Sister Gladys), Rochester (Jun.), Mr. F. (Nurse A. Middleton), Stockholm, Mr. T. (Nurse Feeney). Sister Doris as the Imp was superb, and the best of a good company. The Wanderers, who appeared one after the other upon the stage and severally compared, as the result of their experiences, the Guy's Nurse with other types of the same species, and found plenty of opportunities for "pulling the legs" of their originals—Mr. L., Mr. F., and Mr. T.—were all good, while the Prologue (Nurse Angove) and the various performers in the illustrative tableaux representing the Nurse as "She Was" (Nurse Bierne), as "She May Be" (Nurse C. Middleton), and as "She Is" (Nurse Fletcher) must not be forgotten. A happy "hit" was made by the Imp at the telephone, whose retort, when asked if it were the Take-in H.P. she wanted, "Lord, no! we're in a hurry," brought down the house.

A note at the foot of the programme to the effect that full poetic licence had kindly been granted by the "Wanderers" in dealing with their opinions and sentiments deters us from criticism, of which we should at any rate have been sparing in view of the great enjoyment we experienced.

After the play there was an exciting competition in which the male visitors were allowed twenty minutes in which to make, from the raw materials, and don, a nurse's cap with strings. Much amusement was caused by the endeavours, and more still by the achievements of the competitors. Mr. Lloyd, who had obviously had previous training in the art, secured the trophy, and Dr. Cameron easily won the "booby" prize.

With dancing, refreshments, and the telling of fortunes one of the happiest evenings of the week came to an end, the Matron kindly granting permission for two extra dances, with Mr. Carey at the piano, to conclude the proceedings.

Ward Concerts.

ESTHER WARD.

On Thursday, December 26th, the patients of Esther Ward, by the kindness and help of Sister and her Nurses, held an At-Home and entertained their friends to tea. An informal concert was held and many of the well-worn, but nevertheless much appreciated, songs were heard once again, and selections on the violin and piano were rendered by the Nursing Staff. The afternoon's entertainment was much appreciated by all who paid Esther a visit, and it is desired, through the medium of the GAZETTE, to thank those friends who helped towards the afternoon's pleasure.

QUEEN WARD.

This concert was held on Friday, December 27th, at 2.45 p.m. An excellent programme was arranged, and a large and appreciative audience assembled in an exquisitely decorated ward. Both local and outside talent were well represented, and the entertainment was certainly one of the best of Christmas week.

Miss Rosina Buckmann, already famous in Australia as an operatic artiste, delighted the audience with Tosti's "Good-bye," the "Cuckoo Song," and other pieces from her repertoire. Miss Blake, Miss Foxon, and Miss Dunster were much appreciated, and Nurse Millar was accorded a warm welcome. Mr. Frank Foster was superb, and by special request rendered "Come into the Garden, Maud," which was received with great applause. Mr. Foxon's delightful voice was heard to advantage. Mr. Chapple was, as usual, excellent, and was received with special applause. Mr. Roe's rendering of "Everybody's doing it" was very popular. Dr. Stout convulsed the assembly with his "Mr. Cupid." Mr. Parry-Jones, Mr. Eccles, Mr. Harkness, and the ubiquitous Mr. John contributed to the entertainment. Miss Beatrice Dunn and Mr. Clive Carey were charming, both in their costumes and their rendering of Folk-songs. Miss Oldendorf danced and received a well-merited encore, and Mr. Page, who accompanied throughout, deserves much praise.

Sister Queen who is to be congratulated on the excellence of the decorations, the tea, and the concert, was neatly thanked in a speech by Mr. Chapple at the conclusion of the proceedings.

JOB WARD.

The Job Concert was held on Friday, 27th December. Mr. Eccles opened the proceedings with "When Henry the 1st sat on the throne." Miss Hast then sang two charming songs, which were much appreciated. Tom Clare gave three items at the piano, which "brought the house down." Miss Leonard gave two recitations, and Mr. Constantine Morris sang four songs in delightful manner. Two whistling solos were rendered by Mr. Ransford, and songs were also given by Messrs. John, Harkness, and Montgomery. A duet by Mr. Eccles and Mr. Berry terminated a very pleasant afternoon's entertainment. Mr. Jarvie accompanied throughout the programme.

EYE WARD.

A delightful concert was held in Barnabas on Friday, December 27th, when a large number of visitors and patients were enabled to enjoy a most attractive programme, including both instrumental and vocal talent. Mr. Gervase Elwes, to whom we were especially indebted for coming a considerable distance to take part in the proceedings, delighted the audience with a number of songs from his extensive repertoire. Amongst others to whom the concert owed its success were Miss Dunn and Mr. Clive Carey, who sang in costume; Miss Hunt, who played several violin solos; Mr. Banfield and Miss Wentworth, whose songs were much appreciated; and last, but not least, Mr. H. N. Eccles, whose comic songs formed an effective contrast to the more serious items of the programme. Mention must also be made of Miss Symons and Miss Smith who kindly accompanied the other artistes. Tea was served to visitors and patients at 4 o'clock, and the concert concluded with cheers for those who had contributed to the success of the afternoon.

BRIGHT WARD.

This concert took place on Saturday, December 28th, 1912, at 3.30 p.m. The following was the programme:—

1. Piano Solo ... ... Mr. Eric Hay.
2. Song ... ... Master H. Bothamley.
3. Glee ... ... The Templars' Quartette. (Messrs. Norman Stone, A. C. Dixon, Frank Hastwell, John Halford).
4. Recitation ... ... Mr. Reginald Denham.
5. Song ... ... "The Floral Dance." Mr. G. Seabrooke.
6. Song ... ... "Break, Break, Break." Miss Doris White.
7. Humorous Song ... ... "Breezy Briny Sea." Mr. Eric Hay.
8. Song ... ... "Drake Goes West." Mr. Hastwell.
9. Glee ... ... The Templars' Quartette.

INTERVAL.

10. Glee ... ... The Templars' Quartette.
11. Song ... ... Mr. G. Seabrooke.
12. Song ... ..."The Green is on the Grass again," Miss Doris White.
13. Recitation ... ... Mr. R. Denham.
14. Song ... ... "Home." Master H. Bothamley.
15. Humorous Song ... ... Mr. Eric Hay.
16. Glees ... ... The Templars' Quartette.

NAAMAN WARD.

On Friday afternoon a most successful Concert took place in Naaman ward. Mr. G. Dudley Warmington very kindly undertook the arrangement of the programme, and not only sang himself, but also brought most of the artistes. An excellent selection of items was given: Miss Kupar played the violin, Mr. Rea sang "Songs at the Piano," and Mr. Sidney Clarke sang duet with Mrs. Clarke. A great "hit" was scored by little Miss Jensen, who danced in costume, and was enthusiastically encored. Mr. Mayo provided the comic element with a couple of humorous character-songs. Recitations were given by Miss Elsie Collard and by Miss Harman, the latter of whom rendered a piece, impersonating a French lady's-maid, with great skill and effect. Mr. Thompson contributed two songs, to the great satisfaction of the patients and the rest of the audience. At the end of the concert, all the artistes sang "Auld Lang Syne" in harmony, followed by the National Anthem. There was a large and very appreciative audience, amongst whom we noticed, with pleasure, a number of former Guy's nurses.

DORCAS WARD.

The Dorcas Concert took place on Saturday afternoon. No accompanist being forthcoming, Mr. Hatten very kindly stepped into the breach, and played all the accompaniments at sight. Miss Maye sang, and there were two flute solos. Mr. Thompson and Mr. Parry-Jones sang, the latter repeating one or two of his successes in the Niggers. Mr. Popham rendered an old hunting song. Mrs. Hatten followed with two charming songs and Miss Connie Weatherhead also performed Later on, Mr. Montgomery gave one or two of his inimitable comic songs, adding the topical verses which he had added fo the Niggers, and Mr. Clive Carey found time, amongst all his other duties, to come and sing a couple of Folk-songs, to the great delight of the audience.

ADDISON WARD.

The Addison Concert was held on Saturday, December 28th, and, thanks to the kind assistance of friends inside and outside the hospital, was a great success, and much appreciated by patients and visitors, of whom there was a large attendance. Among the ladies who kindly volunteered their services were Miss Starbuck, who gave some delightful songs; Miss

Jones, pianoforte solos; and Miss Sherris, violin solo. The patients especially enjoyed the violin. Mr. Thomson and Mr. George Parker, from the Westminster Abbey choir, sang some stirring songs, and Messrs. Clive Carey, Thomson, Sheldon, and H. N. Eccles, indefatigable as ever, were in as good form as usual. One of the best items was the Extern Quintette, headed by Mr. Philip Smith; their Farmyard Song was quite the feature of this year's Christmas entertainments. Mr. Saw and Mr. Bailey represented the Hale White "firm" with some good songs, and finally, Mr. Harkness roused us with two old favourites in his best music-hall manner. Mr. Seymour Hicks and Miss Ellaline Terriss who had promised to come, but were prevented by illness, sent a present instead consisting of six large baskets of grapes to the ward. The ward was decorated with yellow and white roses and leaves, made mostly by 43 Addison, Mr. Sherris.

MARY WARD.

On Saturday, December 28th, instead of the usual concert, Sister Mary invited one friend of each patient in the ward, and gave them an excellent tea, which they all seemed to enjoy very much. After tea we had an informal sing-song, at which Miss Starbuck, Miss O. M. Hunt, Nurse Fletcher, Nurse Bevan, and several men in the hospital kindly assisted, and gave us a very enjoyable entertainment.

PATIENCE AND SAMARITAN WARD.

The Patience and Samaritan Concert took place on Monday, December 30th, at 3 p.m., and was a complete success. The patients greatly appreciated the programme, and wish to thank all the ladies and gentlemen who so kindly helped to entertain them. The following ladies and gentlemen sang:—Sister Agnes, Mrs. Osborne, Mr. Eccles, Mr. John, Mr. Parry-Jones, Mr. Sells, Mr. Graham, Mr. P. Scott, Dr. R. Stout, Mr. Harkness, and Mr. Thompson. Mr. J. M. Jarvie kindly acted as accompanist throughout.

CORNELIUS WARD.

This was one of the best of all the concerts. A large number of distinguished performers took part, and kept a crowded audience enthralled throughout the afternoon. The proceedings were opened by Mr. Nichols with a well-rendered overture. Mr. J. Buckstone then gave one of his recitations, which was thoroughly appreciated. He was followed by Miss Nancy Stewart, who sang delightfully, and Mr. Sinclair the inimitable mimic. Miss Ivy St. Helier's song was very popular, and was accorded an enthusiastic reception, while Miss Rosina Filippi captivated the audience with her recitations in a manner of which she alone is capable. Miss Unity Moore was delicious, while Mr. Maurice Harvey and Mr. Hugh Wright also contributed ably to the afternoon's entertainment, and Mr. Tom Clare's telephone monologue was tremendously popular. We were disappointed in not hearing anything more than a kindly little speech from the lips of Mr. Seymour Hicks, who had generously and characteristically taken the trouble to come in person to apologise for his inability to perform in any way owing to the severity of the cold from which he was obviously suffering. The audience was very large, and showed a vigorous appreciation of the highly talented entertainment which they were privileged to hear and witness. To Sir Alfred Fripp for securing the services of all these august people the best thanks of the ward and the hospital are due.

ASTLEY COOPER WARD.

The final entertainment of Christmas week took place in Astley Cooper on the last night of the old year. The ward was fully packed, and the performers were one and all accorded an enthusiastic reception. Mr. H. N. Eccles opened the concert with the popular refrain "Follow the footsteps in the Snow." The chorus, and in fact every chorus of the evening, was voiced with vigour by the audience. Mr. Dunderdale followed with "Susie Green," which was deservedly popular. Mrs. Ayres gave a beautiful rendering of "Abide with me." Mr. Montgomery, who received a great ovation in his own ward, then gave "There's something in the seaside air," with its delicious topical verses, of which we quote the chorus:—

"There's something in that Sister's air,
That makes you feel that you don't dare,
There must be something in that Sister's air
To make you feel as helpless as you do feel there.
Why is it that you cannot make her leave you?
Really, I maintain it isn't fair,
When the Pro. you want to see, to fix a tea for
half-past three,
There's something in that Sister's air."

Miss Ward delighted the audience with her song, and Mr. Schlesinger was prevailed upon to "Keep his foot on the soft, soft pedal," to which he added a neat little verse voicing the general regret that is felt at the departure of Sister Cornelius. Mr. Ransford whistled with pleasing effect, and Mrs. Ayres sang delightfully for a second time. Mr. Thompson followed with that pleasing air "Roaming in the gloaming," which has certainly been one of *the* songs of the week. The ward was still further fortunate in securing the services of Miss Rosina Buckmann, who had delighted a Queen audience in the previous week, and gave Tosti's "Good-bye," with a Maori song, "Waiaito Poi," as an encore. The Extern Quintette

were in great form and, as usual, were recalled. Then came Mr. D. W. John, suitably attired for the occasion, with "Alphonso Spogoni," and "You can do a lot of the things at the seaside," both of which, we need hardly add, were received with wild applause. Mr. Harkness in his Nigger costume gave "Who were you with last night?" and "The Ragtime Violin," and was greeted with vociferous cheers and laughter. The very popular President of the Residents, in his "Johnny Walker" costume, sang "Joshua" with all his remaining voice and tremendous effect; and Mr. Parry-Jones sang the "Ghost of the Violin." "Auld Lang Syne," cheers for Sister Astley, and "God Save the King" concluded an enjoyable and jovial evening.

The Bonfire.

THERE has seldom been a finer Bonfire, and never a hotter one. From beginning to end this magnificent, pagan ceremony of flame, which represents at once the funeral pyre of the Old Year, and the New Year's warm and glowing welcome, was fittingly performed. None of the old rites were allowed to lapse. To the blast of the bugle and the shouts of the fuel-bearers the pile was raised. At the appointed moment the President of the Residents, with the help of his colleagues, set torches to the base of the structure, and then with his arm around the neck of the Founder's statue, gave the signal for the circular dance, the fierce shouting and the song.

"Auld Lang Syne" struggled to be heard above the roaring of the fire, but soon gave place to the popular pæans of the day. Hoarsely-spoken New Year's greetings passed from mouth to mouth; cheers for the Matron, the Sisters, the Nurses, the Superintendent, and the patients were wildly rendered. Then the demi-gods of the hour were sent on their perilous chariot-race around the quadrangle and past the scorching heat of the flames, now leaping higher than the roof-tops. Balconies and windows were packed with onlookers, till even these were compelled to retire in face of the fire's intensity. Outside "the Borough" surged in a black, enthusiastic multitude.

A final linking of arms and encirclement of the flames, a second "Auld Lang Syne," and a hoarse rendering of the National Anthem—while the sparks continued to leap heavenward—ushered in the year nineteen-hundred and thirteen at Guy's.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette." Guy's Hospital, London, S.E.*

A Case from General Practice.

ON first going into private practice, after leaving hospital, one is very inclined to diagnose a serious lesion in every case one sees, and it is with difficulty that one learns that all ulcerated throats are not necessarily diphtheria, nor does severe pain after food always mean gastric ulcers. It is well, however, to bear these more serious diseases in mind when examining a case, but one must be on one's guard against pronouncing some comparatively trivial complaint as serious, and so earning the reputation of a "scare-monger." The following is a case which nearly caused me to fall heavily into this pit-fall, and as the facts are rather interesting, they may be worth recording.

The patient, Martha E——, aged 40, consulted me about an enlargement of her "cheek-bone." She stated that for some weeks past she had noticed it gradually growing larger, but it caused her very little pain. Lately some blood and pus had come from the nostril on the affected side, but this discharge did not appear to be increased by holding the head in any particular position.

On examination, I found a bony swelling bulging out the Canine Fossa and the greater part of the outer wall of the Antrum of Highmore. Slight "egg-shell crackling" could be detected. On inspecting the mouth several carious teeth were found, including the first premolar on the affected side. The interior of the nose showed a little pus on the same side as the swelling, but I was unable to find out from whence it came. On trans-illumination a shadow appeared in the usual position indicating that the antrum was filled up with some substance.

Having seen a case of undoubted carcinoma of the antrum quite recently, and remembering a clinical lecture at Guy's, in which the lecturer laid great stress on the fact that an empyema of the antrum never caused a bony swelling, and if one existed it was nearly always due to a malignant growth, I felt justified in telling the relatives that I feared a growth of a very serious nature. However, before saying anything on the subject, I extracted the premolar tooth on the affected side, and to my surprise a great deal of pus and blood escaped from the socket. On passing a probe I found I could explore two cavities which communicated by a small opening. One was an abscess or cyst cavity, and the other was the antrum, the walls of which appeared normal so far as I could feel. I, therefore, came to the conclusion that the abscess had formed at the root of the tooth, and after expanding the bone, finally burst into the antrum, causing an empyema. For the past six months the cavities have been drained and syringed out daily, with the result that there is very little discharge, the swelling is smaller, and certainly not the seat of malignant growth.

N. S. C.

Renal Calculus.

CLINICAL LECTURE BY F. J. STEWARD, M.S.

GENTLEMEN,—As this is a clinical lecture I propose to deal with the subject of renal calculus purely from the clinical point of view, and shall not therefore go into questions of pathology, composition of stones, and so forth. So we will first discuss some of the symptoms and signs of renal calculus.

The first is pain, and I put it first for two reasons—(1) because pain is the commonest symptom of renal calculus; (2) because it is the most important symptom to the patient, and it is nearly always the one which makes him seek relief, for the great majority of the subjects of this condition come complaining of pain in the side. The character of the pain caused by renal calculus varies immensely, and I shall try to give you some idea of the variations in type and degree. In the first place the pain varies greatly according to the age of the patient. I mention this particularly, because the pain of renal calculus in children is usually very slight or altogether absent, whereas in adults the pain may be very severe. I have only once operated on a young child for calculus in the kidney, a boy æt. 9 years whom I had under my care at the hospital in Great Ormond Street. He had a stone as big as the end of my thumb in the pelvis of his right kidney. But the interesting point is that that boy was admitted to hospital not on account of renal calculus at all, but because he had a vesical calculus. It was in the early days of X-ray work at the hospital, and I had him skiagraphed, although he was known to have a stone in his bladder. The report to my surprise stated that he had also a stone in his kidney, and it was well shown on the plate. The boy's mother was questioned, and she said he had never complained of pain in his side, and there were no other signs of renal calculus present. So I dealt with the stone in his bladder, and asked his mother to watch him. At the end of a month she brought him up again, and said he had never complained, and I had him X-rayed again. Remember these were the days when one was sceptical about some of the results of X-ray examination. Again, there was no doubt that what the plate showed was a stone in the kidney. So I operated, and removed this large stone which I show you. I mention that case to impress upon you that stone in the kidney in children is frequently unaccompanied by pain. Another interesting point about cases of stone in children is that, with vary rare exceptions, they are situated in one of two places—either in the bladder or in the urethra. In the male child the commonest clinical type of stone is an impacted calculus in the urethra. Probably one or two of these appear at the Front Surgery every month. Though I have frequently enquired into the history of these cases I have never heard of an attack of renal colic or renal pain suggesting that the boy had anything the matter with him before, although it was clear that the calculus came down from the kidney.

Next, the pain varies with the *position* of the stone. A stone may be in the cortex of the kidney, or in its pelvis. Dealing first with those in the kidney cortex, the pain in that event is usually comparatively slight, but it is more constant than in the case of stone in the pelvis of the kidney: there are not the violent attacks of renal colic which I shall describe presently. I may mention at once a case which illustrates this. It was that of a man whom I saw some years ago; he was sent to me by an old Guy's man to the Out-Patient Department on account of pain in his back. He had been treated by various people, and had been to several other hospitals. The pain was more marked on one side than on the other—I forget which side. He had previously been treated with liniments and blisters, probably without his case having been carefully gone into. I suspected that there was some underlying cause for his complaint, and I remember speaking of stone in the cortex of the kidney as one of the causes of chronic pain in the back. X-rays showed a stone apparently in the outer border of the kidney, so I took him into hospital and removed it. Here it is. It is a small, round, dark oxalate of lime calculus, and was embedded in the outer part of the cortex of the kidney. It had caused constant aching pain for several years, and, so far as we knew, it was not associated with any other symptom. I will tell you of another case which illustrates this kind of stone. The patient was under the care of Dr. Pitt some years ago, when I corresponded to him, and was a woman who had been in the hospital some time on account of pain in the back. She had been skiagraphed and her urine examined with a negative result, and she had been treated in various ways, but nothing that was done made any difference to the pain in the back. Yet it seemed a genuine case, not functional. Dr. Pitt asked me to discuss the case

with him, and there was no doubt her pain was in the renal region; but it was not associated with tenderness or any urinary changes; moreover, no stone showed on X-ray examination. However, her symptoms were so constant, and had resisted so many forms of treatment, that it was decided to make an exploratory incision to see whether there was any relievable cause to be found. The kidney was exposed but I could not feel anything abnormal so I incised the convex border of the kidney, and palpated all over from the inside. I was on the point of giving it up, when I felt just a small point at which the consistence was different from the rest. It proved to be the edge of a very narrow stone, lying from before backwards in the cortex of the kidney. You see it is not more than quarter of an inch across at its widest part.

Next, let us consider cases where the stone is situated not in the cortex of the kidney, but in its pelvis. The first point I want you to note about these is, that the symptoms produced by a stone in the pelvis of the kidney vary according to the size of the stone. And that is a very useful guide, because you will find it applies also in biliary calculi. Supposing the stones are very small—and as a rule they are multiple when very small—the patient may have a sharp attack of pain, lasting five or ten minutes, starting in the loin and possibly running down to the groin, and then it may be all over; and she may take no further notice until seized with another attack. I had, in Lydia ward some years ago, an interesting case which illustrates this point very well, I shall have occasion to refer to it again later from another point of view. She went originally to the out-patients of the late Dr. Bryant for these attacks of sudden pain, but nothing could be found to account for them, and Dr. Bryant was not sure of the diagnosis. The pain was on the right side. However, he suspected the possibility of either biliary calculus or renal calculus, and advised her to examine her urine and fæces carefully after an attack. She did so, and found that after the pain she passed a little stone, such as I show you. These stones vary from $\frac{1}{32}$ to $\frac{3}{16}$ of an inch in diameter. After she had had one or two more attacks I admitted her into Lydia ward, and operated upon her. She had more than 100 of these stones in the pelvis of the right kidney. Her symptoms were sudden violent attacks of pain which made her feel bad, but were quickly over, and she had no hæmaturia or other symptom. The explanation is that these stones, being small, pass rapidly down the ureter. If the stone is bigger and gets into the ureter, it takes more time to pass down; and the ureter contracts more violently, so causing a severe attack of typical renal colic. About eighteen months ago, when I was doing duty in Clinical, I saw such a case, which had just been taken into John. The history was that he had been suddenly seized with a most violent pain in his left side, he had been sick, and he was then lying doubled up with pain, although he had had morphia. He had a very feeble pulse, and cold clammy skin, and was writhing in agony. This lasted for some time, in spite of a further dose of morphia. After the pain subsided he passed a good deal of blood in his urine.

If the stone is a little larger still, it may, instead of passing all the way down, become impacted in the ureter. In these cases the pain usually passes off gradually, not suddenly. It may be quite absent for a day or two, and then recur from time to time, as the ureter, as it were, gathers strength to have another push at it. So the pain in this case is of the recurring type. Not very long ago I had, in Lydia ward, a woman who had such a condition. She had a tumour in her loin, which was due to hydronephrosis, associated with calculus in the ureter, and I show you a skiagram of the case. She had had pain for several months, beginning with acute attacks, and associated with exacerbations. X-ray examination showed an oval stone lying in her ureter, at about the level of the brim of the pelvis. I removed the stone, of which I show you a photograph. It gives you an idea of the size of stone which may be impacted in the ureter. When there is a calculus a little larger still it will not go into the ureter, and so has to remain in the pelvis of the kidney; and then there is again a different type of pain. There is pain which lasts a few hours at a time, and is brought on by exercise, or even by movement: riding in a 'bus, or even in a train, will bring the pain on. The stone may be irregular in shape. I show you a stone which was removed from a man who had no renal colic, but had had frequent attacks of renal pain. One corner of such a stone may get caught in the orifice of the ureter, and give rise to an attack of pain, lasting any time from a few minutes to a few hours, till the stone falls back into the pelvis of the kidney again. These attacks of pain are not like the constant ache of a stone in the cortex. They are more severe attacks, but not so severe as typical renal colic. There is nearly always hæmaturia after the pain.

In 1910 a patient was admitted under my care on account of pain in the back, which he had had

for some time, and which became worse on walking. Probably other things brought it on as well. It spread round from the left side, and had been associated with hæmaturia on four occasions, the first time eight weeks previously. He had had three further attacks at intervals, the last a week before admission. X-ray examination showed a stone in the pelvis of the kidney, and I show you the stone which I removed.

If the stone is larger still, it may cause no pain at all, because it fits into the pelvis of the kidney so tightly. So that pain may be due, first of all, to the contraction of the ureter in renal colic; secondly, to the gripping of the hard surface of the stone by the kidney pelvis, and the congestion which is set up by the presence of a foreign body. And finally a very large stone may cause no pain at all. Here are two enormous stones that I removed from the pelvis of the kidney in a case where there was no pain at all. His history was that 30 years previously he had an attack of renal colic, but had not felt anything the matter with his loin since that time. As a matter of fact, he was admitted on account of multiple joint disease associated with some pus in his urine, which was found to be due to these stones.

Now we come to the other symptoms. I put hæmaturia next, because it is the next commonest. The hæmaturia of renal calculus is very frequent, and is of two types. First, there is the hæmaturia associated with renal colic; it is always present where the colic is severe. Then there is the type of hæmaturia brought on by exercise, or jolting, when the stone is lying in the pelvis, or fixed in the cortex. In cases of renal calculus you will nearly always find that the hæmaturia is associated with pain, and I want you to make a special note about that, because it is very useful in diagnosis. The next most frequent cause of hæmaturia is tuberculosis of the kidney, but as a rule this does not cause pain. So in most cases you will be right if you say hæmaturia + pain means renal calculus; hæmaturia — pain means tuberculous kidney.

Now we come to pyuria, which, if looked for, is found fairly commonly in cases of renal calculus. Of course, it is due to the fact that stone in the kidney sets up some irritation, being a foreign body, and that irritation causes pus formation. In some cases the amount of pus is very large, owing to suppuration of the kidney as a whole.

The following case is an example of this condition. The patient, a woman, was very emaciated, looked very ill indeed, and had had a high temperature for some weeks. On examination, one could feel a large tumour in the right loin, and there was abundant pus in the urine. I explored the tumour, and found it to consist of a huge pyonephrosis, seven or eight large calculi lying in a loculated bag of pus. The kidney was removed, and the patient did very well.

Next, I want to refer to calculous anuria. If one kidney is completely destroyed by renal calculi, the other kidney may be put out of action by a calculus which has become impacted in the ureter, with resulting anuria. Though such an event is rare, it is important to remember the possibility. A number of cases of anuria have been recognised as due to calculus, and have been operated upon successfully. If a patient gets anuria, therefore, remember that there is not much time to lose; and to recognise calculus as a possible cause may result in the saving of the patient's life.

In cases of suspected calculus, palpation is very important and in the first place you may find that the kidney is tender as a whole. Or if you do not find general tenderness you may, especially in the cases in which there is a stone in the cortex of the kidney, find deep tenderness at one spot. If you systematically go over the loin exerting fair pressure with your thumb, you may come to one spot where the pressure causes the patient to jump. Palpation may also reveal the fact that the kidney is enlarged, and that enlargement may be due to the presence of pyonephrosis. Or it may actually be palpable from the size of the stones. The gentleman I have spoken of, who had these enormous stones, is a case in point. He was very thin when he came to me for examination, and I could feel them very well through his abdominal wall. Very rarely in the case of multiple calculi in the kidney you can actually feel the stones grating against each other. I have only felt that once, and it was in the woman I told you about, who had these tiny stones; on pressing firmly while she breathed deeply, one could feel the stones grating against each other quite plainly.

Now, as to X-ray examination. To what extent is that method of examination reliable in the case of stone in the kidney? I think you can say this now, that if the result of X-ray examination is positive, *i.e.*, if a stone shows on the plate, that is reliable evidence. A few years ago the position was not quite so clear. On the other hand, you should not necessarily

accept negative evidence, *i.e.*, if X-ray experts say they see no evidence of stone, it does not prove that there is no stone present. With regard to the circumstances which may produce this negative result, the first is, that the composition of the stone may be such as to account for the lack of shadow; some calculi are much less opaque to the rays than are others. The most opaque is oxalate of lime, and the least opaque is a phosphate calculus. Again, the stone may be so small that it does not cast a recognisable shadow; the narrow stone which I showed you is a case in point. Again, the patient may be so stout that it is very difficult to pick out a definite shadow; and the same may be true if there is a pyonephrosis.

Finally, I have had one case in which the failure was due to the stone being in a horse-shoe kidney.

The patient was in Job ward in 1910. He had attacks of pain on the left side, but also to a slight extent on the right; and had twice been X-rayed on the left side, but with a negative result. He had had several attacks of hæmaturia, and had another in the ward. Another X-ray examination was therefore made, and there was the stone showing on the plate quite plainly. At the operation I found that he had a horse-shoe kidney, and that the stone easily rolled away to the other side. That accounted for his having had pain on both sides, and for the fact that the stone was missed on two X-ray examinations. If both sides had been X-rayed the stone would probably have been found at the first attempt.

Treatment must be dealt with very briefly. If there is but one stone and it is comparatively small, you may tell the patient that he need not have it removed at once, as the effect of solvents can be tried. There are a number of solvents on the market, but I don't think they are of much value. The only important solvent is water. If the patient is a poor man, get him to drink large quantities of distilled water. If he can afford it and is anxious to go abroad, send him to Contrexeville. There is no doubt that stones are passed as a result of taking Contrexeville water. I have known several cases in which patients were advised to try a "cure," and have passed their stones. But I should only consider that course if the stone be small and single. If the stone is large, or if there are several, you should advise operation, because they will sooner or later cause destruction of the kidney; moreover, the operation is, now-a-days, very successful and practically devoid of risk.

London Bridge and the Borough in the Eighteenth Century.

(*Continued from page 530.*)

XIV.

THE PATIENTS.

"*'Twas strange, altho' they got no fees,*
How still they watch'd by twos and threes:
But Jack a very little ease
Obtain'd from them;
In fact, he did not find M.D.'s
Worth one D—M."

Jack Hall, TOM HOOD.

There are no pretty things to be said of the Nursing Staff of the eighteenth century. From the list of officials in the early years of Guy's we learn their numbers, rank, and pay: the Matron received £50 yearly, the eleven Sisters, £11 apiece, the eight Nurses £16 each, and the twelve "watchwomen" £10 8s. These salaries seem less paltry when it is remembered that money had then at least five times the purchasing power it has to-day. The regular day staff appear to have been quite distinct from the night nurses, or "watches," who, according to Golding, did not reside in the hospital, but were women of good character, hired at the weekly allowance of 7/6 to sit up during the night in the wards and, towards morning, were permitted to return to their homes for the day. Two other officials were the "brother" and the "sister belonging to the lunatics," at £35 and £25 per annum respectively. Although no more male lunatics were admitted after 1793, the patients already within the hospital must have been fairly longlived, for the "brother" was still drawing his pay in 1819.

It will come as a surprise to those who are only acquainted with present conditions to learn that patients were not admitted to the benefits of the hospitals of those days free of cost. When, in 1570, the parishioners of St. Andrew Undershaft arranged for the reception of Margaret Merriman, an impotent person, into St. Thomas's Hospital, they engaged to pay twelve pence a week for her. Allys Black, therefore, might count herself lucky to be "received into the house for twelve weeks at 8d. per week," for those sums in Tudor days would represent nearly twelve times as much under present conditions. As it was those who brought her were "bound in the sum of £3 6s. 8d. to take her away at the end of the twelfth week."

So, again, 20 shillings "yerely for the space of six yeres is to be paid for William Kyng who ys to be Dysmemburyd of one of his leaggs, and yf he may be

Curyd wtin one yere and a halfe," etc. John Hood was sent to the Locke, paying weekly, 20d.

Therefore, later on, Thomas Guy, "when he met with such diseased and friendless Objects as wanted the help of an Hospital, . . . was used to send them to St. Thomas's, with directions to the Steward to supply them, at his Expence with Cloaths and such other Necessaries as are not provided by the Hospital." Guy was an unusual type of "miser"! Still, it was the custom of the day to make the parish to which a pauper patient belonged contribute to his maintenance within the hospital, and Guy's own institution followed the practice and usage of St. Thomas's. The philanthropist, John Howard, visiting Guy's in 1788, saw a poor woman parting with 2/9 for the nurse, and 6d. for the Steward. Foul patients paid 7s., and every patient on admission had to deposit 20s., or find security for his burial. St. Thomas's was even more expensive; there, foul (or venereal) patients paid 10/6, besides 4d. a day; and all paid the nurses for washing their linen.

The contract which follows is copied from an actual document retained by the Steward of this hospital on the discharge of a pauper patient from Clapham in the eighteenth century:—

To the Worshipful the PRESIDENT, TREASURER, and GOVERNORS of the Hospital founded at the Sole Costs and Charges of THOMAS GUY, Esq.

The Humble Petition of *Phillip Westrup,*
one of the Poor of the Parish of *Clapham.*

Sheweth

THAT your Petitioner is afflicted with *a sore Leg* and being in low Circumstances and destitute of Funds whereby to obtain a Cure, most humbly desires your Worships would be pleased to admit *him* into the same Hospital.

And as in Duty-bound shall ever pray.

We the Church-Wardens and Overseers of the Poor of the Parish abovementioned, do hereby promise and agree for ourselves, and our Successors, to and with the GOVERNORS of the said Hospital, that if they shall please to admit the said Petitioner, We will supply *him* with clean Body Linen every week, and we will be Security for the Payment of Fourpence a Day for the Maintenance of *him* of which we promise to Advance beforehand, by Way of Deposit, Nine Shillings and Fourpence on the Day of Admission for the first Month and so to continue to Advance the like Sum of Nine Shillings and Fourpence on the first of every successive Twenty-eight Days, so long as *he* shall be continued in the Hospital, and will receive *him* when *he* shall be discharged from thence; and if *he* shall die there, We will forthwith, upon our receiving Notice thereof, take away *his* Body or pay the Fees for *his* Burial to the Steward of the said Hospital, for the Time being, according to the Usage in that Behalf. Witness our Hand this Day of 176

Witness *Thomas Richards, Beadle.*

Note.—The Signature of the Officers to be attested by the Beadle of the Parish or by a substantial Inhabitant, where there is none.

Hamnett Townley,
Churchwarden or Overseer.

*** The Deposits to be paid at the Hospital or otherwise the Messenger to be paid One Shilling, who shall be sent for them.

Contemporary manuscript notes on the covers and margins include :—

"*Phillip Westrup on his Discharge from Guy's Hospital, £1 3s. 2d., August 13th, 1771, No. 19.*

"*Admitted, 13th June* / *Discharged, 8th August* } *1771.*

	£	s.	d.
In on the House Subsistence, 56 days @ 4d.		*18*	*8*
Petition on Admission		*2*	*6*
	£1	*1*	*2*

12th August, 1771, Received the Contents for
Mr. Thomas Callaway, Steward.
William May, Clerk."

There are also a couple of simple sums in addition and multiplication; and

"*Wrote to Mr. R., 9th August, '71,*"

and, finally,

"*Received for the Sister* { *Due to Sister Job for Washing Body Linen, 8 weeks at 3d.* = *2s. 0d.*"

In founding his own institution, Guy repudiated the interpretation popularly given to the word Incurable, as comprehending "such as laboured under distempers, loss of limbs, blindness and other natural or accidental deformities, and even age itself"; perceiving that "if taken in such an extensive sense his Hospital must soon have become an Almshouse, into which (to use his own words) Parishes, as well as particular persons, would shift off from themselves the burthen of their dependents and indigent relations, to be provided for during their lives; which he foresaw, and often spoke of with great concern to several of his Executors and other persons." Accordingly, his Will directs that the new hospital is to receive and entertain "four hundred poor persons, or upwards labouring under any distempers, infirmities or disorders *thought capable of relief by physic or surgery;* but who, by reason of the small hopes of their cure or the length of time which for that purpose may be required or thought necessary are or may be adjudged or called incurables, and as such, not proper objects to be received into or continued in the present hospital of St. Thomas, or other hospitals in and by which no provision has been made for distempers deemed or called incurable."

How could Guy foresee that in thus fostering a disposition to deal with cases "*the mere despair*"

of other people's Surgery and Physic he was exposing his "men," despite their innate modesty, to the unjust charge of possessing an over-good conceit of themselves, that in some quarters is still regarded as their outstanding characteristic ?

At any rate, the graver nature of the cases admitted goes a long way to explain the relatively high death rate (119 per thousand) at Guy's from 1730 to 1800, against 86 per thousand at St. Thomas's.

It is quite possible that the tradition that Guy's was intended for incurables (in the popular sense of the word) was due to the continued circulation of engravings still bearing that dubious expression. The second edition of Strype's Stowe published in the latter half of the century contains a reproduction of the large view which forms the centrepiece of John Bowles's plate issued in 1724. The latter was, in all probability, engraved at an even earlier date from the architect's original elevation. In the later publication, the label inscribed "Guy's Hospital for Incurables" (prepared in the first place before Guy's change of plans) is still retained.

In its early years Guy's Hospital managed to accommodate some 1,080 patients in its twelve wards and 435 beds in the course of a year; but for a long time the number of out-patients was relatively small. On one day in 1735, we learn from Maitland, there were no more than 16. Only in 1795 did their numbers justify the appointment of an unsalaried Assistant Medical Officer to deal with that department.

The "Take-in" was already established in the eighteenth century. One of the dressers was in waiting for a week by rotation to take the care of accidents, and the surgeon of the week was always in readiness to be called on, if wanted for an operation. "When an accident is brought in, the surgeon whose week it is receives notice, and, according to the nature of such accident, he either goes immediately over, or trusts the management of it to the dresser who is in waiting there.

In the ordinary course patients were admitted at 10 o'clock on Wednesdays at Guy's (or on Thursdays at St. Thomas's) when the week's take-in began.

"Each surgeon sees the whole number of his patients once a week, when he *presents out* those who are cured." This refers to a custom which then obtained, under which a patient before his discharge was made to appear before the house-committee to thank them for his treatment. Even after this ceremony had fallen into disuse, the older physicians would announce that a patient was fit to be discharged by the words "Present him!"

Another relic of a more scholarly age are the initials P.O., still blindly inscribed by the clerk upon out-patients' "letters," where the foregoing prescriptions are all to be continued. At one time, Wilks tells us in his notice of Dr. Cholmeley, the letter P was written with the same intention upon the bed-letters in the wards, and that when it was M.M. c. M.S. that was to be repeated, the Borough patient preferred to derive the word from *purgo,-avi,-atum* rather than from the orthodox *pergo, perrexi, perrectum.*

"Particular bad cases are seen every day if necessary, because, by a rotation, one surgeon at least visits the hospital every day. . . . . At St. Thomas's Hospital the days of attendance are Tuesday, Thursday, and Saturday, at 11; at Guy's, Monday, Wednesday, and Friday, at the same hour. At Guy's we visit the whole house every Monday and Friday. . . . . On Saturday, the Physicians and Surgeons all meet and go in pairs to visit all their patients. . . . . Friday is the general day for operations and for grand consultations. . . . . Notice of Operation is stuck up at the surgery of each hospital mentioning the operation and by whom performed."

Towards the end of the eighteenth century St. Thomas's possessed two operating theatres, that for the male patients in the third square; that in the front square appropriated solely for those of the female sex. The outlines of the latter may still be traced in the attics above the old Treasurer's House in St. Thomas's Street.

(To be continued.)

NOTE.—In the fourth column of the last essay two dates were given, by a slip of the pen, as 1660 and 1668. Since the reference was to the association of the two Borough Hospitals, we trust it was sufficiently obvious that they should have been 1760 and 1768.

Papers by Guy's Men.

W. Arbuthnot Lane, M.S., F.R.C.S.: Chronic Intestinal Stasis (illustrated).—*Lancet*, 21st December, 1912.

J. G. Porter Phillips, M.D., B.S.: Nervous and Mental Symptoms in a Case of Addison's Disease.—*British Medical Journal*, 21st December, 1912.

J. Lloyd Roberts, B.A., B.Sc., M.D., B.S., M.R.C.P., F.R.C.S.: Early Signs of Mediastinal Tumours.—*Lancet*, 21st December, 1912.

E. P. Minett, M.D., D.P.H., D.T.M.&H.: Drinking Water Supplies of the Colony (British Guiana). A Critical Review.—*Journal of Royal Agricultural and Commercial Society*, Vol. II., 3rd Series, No. 2.

A. H. Tubby, M.S., F.R.C.S.: On Shock (with discussion).—*Clinical Journal*, 1st January, 1913.

Appointment.

Civil.

Stevens, T. G., M.D., M.R.C.P., F.R.C.S., has been appointed Consulting Anæsthetist to the Royal Bethlem Hospital, S.E.

First Annual Report (Abridged) of the Dental Treatment at the Worthing School Clinic.

BY C. DOSWELL WALLIS, L.D.S., R.C.S. Eng.

THE Worthing School Clinic was one of the earliest to be approved by the Board of Education under the provisions of the Education (Administrative Provisions) Act, 1907, and the scheme of dental treatment was commenced in September, 1911.

The Clinic comprises four rooms. One is a waiting-room, and opening from this is another room where toys, etc., kindly provided by people in the town interested in the Clinic, are placed for use by the children waiting for treatment. A third room, with a separate exit directly to the open air, is used as a recovery room after gas cases, etc.

The surgery is equipped with a hydraulic pump chair, adjustable to suit children of the youngest or oldest school age. A cupboard in a convenient position has been fitted with drawers, etc., to contain all the instruments, drugs, materials, etc. A spittoon of white porcelain, with water laid on, has been fitted in a position adjacent to the chair. A dental engine of the usual type, and a bracket table with glass top and adjustable arm have been provided. All the metal parts are of oxidised copper, as so much attention would have been necessary to keep nickle-plate in a bright condition. Artificial light is provided by means of an adjustable electric pendant and a water globe reflector to focus the light upon the mouth.

The work undertaken is very beneficial, and has been a very great success; but, unless much more time is expended on it in the near future, little permanent good will result.

By the original arrangement for dental treatment, it was proposed that I should examine all the children over five years of age in the Infants' Departments, and treat such as were found to require attention; also to treat such cases amongst the elder children as were urgent (*e.g.*, pain or what-not, causing the child to lose attendance or the full benefit of the instructions given); all the children so treated to be re-examined within six months and further treatment, if necessary, carried out.

The enormous amount of work that I have found required to be done, however, has rendered it quite impossible to carry out this programme in the very small amount of time at my disposal.

The procedure is as follows: Notice of an intended visit to a school is sent by the Clerk to the Committee, and on the date arranged the necessary instruments and record books are taken there and the school nurse is also in attendance.

The records made at this inspection show the extent of the defects found in each case, and printed notices stating the object and aims of the scheme of treatment are then sent from the Education Office to the parent of each child requiring treatment.

A form to be signed if treatment is desired, accompanies the notice, and upon the back of this is printed the scale of fees charged. On the return of these forms duly signed, an appointment card is sent fixing a time for attendance at the Clinic. Information as to the circumstances of the parents is obtained, this being the basis of the scale of fees, and pre-payment of such fees is required.

The statistics for the year are as under:—

NUMBER OF OPERATIONS PERFORMED.

Examinations.	Fillings.	Extractions.		Dressings.
		Tempy. Teeth.	Permt. Teeth.	
Boys	23	339	51	5
Girls	57	297	90	28
Total ...	80	636	141	33

NUMBER OF CHILDREN EXAMINED AND NUMBER TREATED.

No. of Examinations.	Total No. Treated.	Fillings only.	Fillings and Extractions.	Extractions only.	Refused Treatment.
Boys ... 594	134	6	8	120	—
Girls ... 695	167	14	19	134	—
Total...1289	301	20	27	254	—

RESULT OF THE EXAMINATION OF THE CHILDREN'S TEETH.

Age.	No. of Children Examined.	Temporary Teeth.			Permanent Teeth.			
		Sound.	Carious Saveable.	Carious Unsaveable.	Sound.	Carious Saveable.	Carious Unsaveable.	
4	4	57	4	19	—	—	—	
5	296	4,483	147	995	329	4	—	
6	353	4,709	135	1,567	1,109	25	11	
7	174	1,772	30	778	1,218	46	23	
8	80	488	4	461	807	17	35	
9	81	332	1	344	948	38	41	
10	97	340	—	349	1,419	45	92	
11	61	122	—	133	1,097	53	76	
12	66	68	2	77	1,339	69	118	
13	69	46	—	47	1,405	108	151	
14	8	—	—	1	189	7	13	
Total ...	1,289	12,417	323	4,771	9,860	412	560	
Seniors..	382	908	3	951	6,397	320	491	
Juniors..	907	11,509	320	3,820	3,463	92	69	

No. of children on the registers of the schools		3,594
No. of children under 8 years of age who have been examined		907
No. of children over 8 years of age who have been examined		382
No. of those examined whose teeth need attention		1,143
No. of those examined whose teeth are all sound		152
	Up to 8 years of age.	Over 8 years of age.
No. of temporary teeth sound ...	11,509	908
No. of temporary teeth saveable ...	320	3
No. of temporary teeth unsaveable ...	3,820	951
No. of permanent teeth sound ...	3,463	6,397
No. of permanent teeth saveable ...	92	320
No. of permanent teeth unsaveable ...	69	491
No. of Forms sent to parents notifying necessity of treatment		734
No. returned signed by parents desiring treatment		347
No. of children treated...		301
No. of attendances made by such children ...		520
No. of extractions		777
No. of fillings		80
Amounts received from parents towards cost of treatment		£5 6s. 11d.
Cases for Gas		37

It will be seen that of the children requiring treatment in only 30 per cent. of the cases were the parents willing for treatment to be given; these were, however, so numerous and required so much doing that no time has been available for re-inspection, and no efforts were made to get the other children needing treatment to the Clinic. It is, therefore, quite patent that the present scheme is inadequate and requires to be extended in the immediate future.

I have made various suggestions for educating the parents, teachers, and others, on this most important subject. This can be accomplished by means of lantern lectures, pamphlets, and other literature upon dental hygiene, dental decay, the value, care, and use of the teeth, and such like.

One lecture was given to the Teachers which was very well attended and most successful, and it is hoped to do more in this direction during the coming winter.

A New Year's Resolution.

While Greek meets Greek, or Turk encounters Bulgar
(To be precise and gratify the vulgar);
While doctors disagree concerning panels,
And add a stormy chapter to their annals;
While nations squabble, and a proud profession
Is staggered by a Chancellor's transgression—
We'll stand aside and modestly remain
Their humble slaves—the patients and the slain.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—ED., G.H.G.]

Dr. Moxon on the Function of the Doctor.

DEAR SIR,—Will you allow me to correct a little mistake into which Dr. Lauriston Shaw fell in his quotation from our old teacher, Dr. Moxon? Dr. Moxon did not say that it was the chief function of the doctor to protect his patient against the State. He was not thinking of the patient in his relation to the State, but of the patient in his relation to the Race. In other words, the dictum referred to had a social or biological and not a political bearing.

The paper in which the remark is to be found was published in 1876, and it was re-produced with other essays in a little volume, which I fear may be now out of print, called "Pilocereus Senilis." (I hope your library has a copy).

Here is the passage in full:—

. . . "Your learning, all your teachers ever taught you, gives you a unitship in such and such a place in your Race. But you will yourself have to make it rich and good by what your own five senses can store from Nature as a fund for your Intelligence to use in the current life you belong to.

"I am not now extolling that forward progress of the Human Race in the knowledge of Nature, of which progress the said Race is so proud. I am not speaking for the Race; the Race is strong enough to take care of itself. I am a Physician, and therefore I have charge of the good of the Units as against the Race, which is always trying to displace them in favour of new Units its profusion has produced. Such opposition to the Race is the function of the Physician. Therefore it is that he is not, and never will be, in great consideration in the Race." &c.

The essay was entitled "Nothing." It was typical of Dr. Moxon in the half-serious vein which those of us who knew him well, as his ward clerks or otherwise, were wont to associate with much of his teaching. It was a vein reminiscent, at times, of Swift, but more often, perhaps, of Carlyle, and still more often of Ruskin. He was discursive sometimes, obscure now and then, at times brilliant, often singularly penetrating and wise, always suggestive, and never dull.—Yours faithfully,

"*Haec olim meminisse juvabit.*"

December 23rd, 1912.

Good Resolutions for 1913, by a Sorrowing Notice Board.

DEAR MR. EDITOR,—I did have a hot time on New Year's Eve! But now that I have recovered from the shock I don't mind my appearance so much. Perhaps it may have been sent to rouse me to new efforts, for one does get sleepy looking down on the same scene year in, year out. Just as I was thinking what I could do to commemorate my escape from the fiery furnace, I heard one of the Porters remark, "Hem! his day is done!" "Not so sure," drawled another. "Looks a bit the worse for wear, but Saltmarsh will have him touched up." Then Sister Lydia, on her way over from Downs, noticed my charred remains. I felt sure help was approaching, but instead of her usual sympathetic smile she remarked with asperity to Sister Charity, who was posting letters, "That old board might as well have been completely burned for all the good it does." I felt very hurt, having for years done my duty as well as I could. It is not my fault if the visitors troop in. I tell them plainly "only 3 allowed in the wards at a time."

Then I thought I would commemorate my escape by trying to be more useful and help the Nurses, so I hopped round to Bart.'s to see if the Board there managed his work better. "Of course I do," he said, rather roughly. "I insist on the Porter seeing all cards at the barrier!" I ventured to suggest this might overwork our Porters. "Well," he said, "it's just as you look at things; it is surely easier to count cards than clear up your bit of a garden after the Borough has been playing around. We do things in an orderly manner here." "Oh, you are not the only one," chimed in St. George's, who had just strolled in, "our Sisters give out two kinds of cards—one for ordinary visitors and one for friends of patients on the danger list." "Softly, softly," jeered Bart.'s, "don't expect too much from that old 'Guy,' his bones are too stiff to move quickly." "Well, I never like to commit myself," said St. George's, while he puffed away at his evening pipe, "but I did think old 'Rip' was beginning to wake up!"

Dear Mr. Editor, do you think you could help me? I can't very well go to the office, and Sir Cooper always slips down the steps on the other side.—Yours very truly, CINDERS,

(The Visitors' Notice Board when on duty.)

Editor's Note.—The Fire this year was high and fierce, and several repairs have been necessary.

Some Acquired Lesions of the Jaws.

A CLINICAL LECTURE on the above subject was delivered by Mr. Lewin Payne on Wednesday, December 11th.

The lecturer dealt first with acquired lesions of the palate; and in order to bring out the contrast between congenital and acquired cleft palate, shewed a patient who had suffered from a complete congenital cleft palate and double hare-lip. The hare-lip had been successfully treated by operation. It had not been possible to close the palatal cleft completely, by surgical means, with the result that the patient's speech had been but little improved. A vulcanite denture had been made, covering the small aperture which remained in the hard palate, and a velum was attached to take the place of the cleft in the soft palate. A month's use of this contrivance had been accompanied by marked improvement in respect of speech.

The lecturer emphasized the fact that the prognosis, as regards the recovery of speech, is much more favourable in the acquired than the congenital variety. After citing instances of perforation of the palate, resulting from injuries (such as falls, gunshot wounds or explosions) and from gummata, Mr. Payne went on to describe the results of extensive operations upon the maxillæ or mandible for the removal of malignant neoplasms, and the methods by which dental prosthetic treatment might lessen the subsequent discomfort of the patient. He pointed out that, although the pressure of a dental apparatus, however carefully and skilfully constructed, might be a distinct factor in determining a recurrence of the disease, this fact should not be brought forward as a sufficient reason for omitting prosthetic treatment. The plight of a patient on whom extensive operative measures, involving the removal of large portions either of maxillæ or mandible had been performed, was so miserable, that the comparative comfort obtained from a suitable prosthetic appliance fully compensated, in most cases, for the slightly increased danger of recurrence.

Reviews, etc.

An Operating Theatre in Private Practice. By C. Hamilton Whiteford, M.R.C.S., L.R.C.P. Price 3s. 6d. net. (Harrison & Sons, Pall Mall).

This little manual contains some useful suggestions for the equipment of a small, private operating theatre. Although the prevalence of hospitals and nursing homes is rapidly eliminating the need for such theatres, and increasing specialism is taking all but minor surgery out of the hands of the private practitioner, there are still districts in which the existence of some such provisions as are described in this book would be an undoubted boon. Most of the necessary descriptions can, of course, be obtained from the ordinary text-books, but there are certain points, resulting from the author's experience, which should prove valuable.

Pass List.

University of London.

M.D. EXAMINATION.

Branch I.—Medicine.
H. F. Renton.

Branch IV.—Midwifery.
Dunderdale, G. | Stout, R.

University of Cambridge.

SECOND EXAMINATION FOR MEDICAL AND SURGICAL DEGREES (NEW REGULATIONS).
Part II.—Pharmacology and General Pathology.
E. S. Taylor.

THIRD EXAMINATION FOR MEDICAL AND SURGICAL DEGREES (OLD REGULATIONS).
Part II.—Surgery, Midwifery, and Medicine.
The following have now satisfied the Examiners in all three sections:—

Adams, F. S.	Maile, W. C. D.
Chaning-Pearce, W. T.	Seabrooke, A. S.
Clifford, A. C.	Warner, C.

Zamora, A. M.

EXAMINATION FOR DEGREE OF M.C.
Examined and approved.
Saner, J. G.

ACTS FOR DEGREE OF M.B.
The following has duly kept the Act:—
Depree, H. T., B.A.

DEGREES CONFERRED.
M.B., B.C.—Depree, H. T.

Rugby Football.

GUY'S v. OLD MILLHILLIANS.

On a soft turf this match was played at Honor Oak Park on Saturday, December 21st, and ended in a somewhat easy win for the Hospital. This fixture brought the first half of the season to a close. The team showed greatly improved form on their recent displays, and, gaining confidence as the match proceeded, points were piled on somewhat rapidly. If Medlock or some other place kicker of ability had taken the kicks at goal, probably a higher total still would have been reached. It seemed almost a pity the opportunity was not seized on to give Medlock as much practice as possible.

The first try was gained by Horsley, who signalled his re-appearance in the First XV. by a sterling display. The second try was obtained by Rook, and the third by Medlock, who very cleverly eluded the opposition and grounded by the post. All the backs were playing well, and smart handling sent the ball to Harkness, who "sold the dummy" very neatly, and passed to Pritchard, who had but to run on to register the fourth try. Medlock's effort was converted, and ends changed with Guy's 14 points up.

The second half was not far advanced before Rook sent Curle over the line. Then Medlock came round on the blind side with full speed up and dashed over, taking Rook's pass delightfully. It was good to see Knott's excellent showing, in this his first match with the First XV. He has very safe hands and an amount of resolution that is valuable. He was the next try getter. Rook followed by pretending to pass and then going on single handed, while before the end Harkness added a couple more tries. Millett converted one try and Parry-Jones a second, so that the final score read: Guy's (3 goals 7 tries) 36 points; Old Millhillians, nil. Team:—

GUY'S.—H. Millett (back); F. A. Knott, G. B. Pritchard, A. H. Harkness, C. L. Curle (three-quarters); C. H. Medlock, A. F. Rook (halves); O. Parry-Jones, W. S. Stranack, M. Tweed, L. Horsley, A. L. Liebson, A. S. Anthony, H. P. Whitworth, A. H. Biddle (forwards).

REMARKS.—Biddle was pressed into service, Guy's being short. He did well, and will not be so diffident about playing next time. The whole team played well, giving very little cause for criticism. Tweed, Stranack (especially in the line out), Parry-Jones, and Horsley were the pick of the forwards. Plenty of devil and go was exhibited. The pack will be a great one yet. C. H. Medlock played one of his best games; Rook served him well. The remaining backs played excellently; Knott should tackle low; shoulder or head tackles are a waste of energy.

Marriages.

HIND—MILLER.—On December 17th at Shepton Mallet, Somersetshire, by the Rev. R. L. Jones, Guy Reginald Hind, M.B., B.S., younger son of Wheelton Hind, Esq., M.D., F.R.C.S., F.G.S., of Stoke-on-Trent, to Rose Gwendoline, daughter of Ellis Miller, Esq., of Bristol.

DAVIDSON—TIPPETTS.—On October 24th, at Lahore, India, by the Bishop of Lahore, John Davidson, Indian Finance Department, to Lilian Mary, daughter of the late Surgeon-Major-General A. M. Tippetts.

SAUL—DAVIS.—On December 23rd, at St. Mary's Church, Johannesburg, Alec Linford Saul, M.R.C.S., L.R.C.P., L.D.S., third son of the late G. F. Saul and of Mrs. Saul, of Lymington, to Rosa Eleanor, only daughter of A. W. Foster Davis, of Benoni, Transvaal (By cable).

Death.

BARTHOLOMEW.—On December 10th, at 31, West Hill, Wandsworth, Alfred Aldam Bartholomew, L.R.C.P., and L.R.C.S. Edin., L.D.S., R.C.S. Edin., aged 52.

Ed.—J. A. R.

GUY'S HOSPITAL GAZETTE.

VOL. XXVII., No. 641.] JANUARY 18, 1913. [SIXPENCE.

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Passim.

WE regret to note the continued absence of Mr. Targett, owing to his severe illness, and offer him our sincerest sympathy. We trust it may not be long before we are able to welcome him back amongst us again.

THE Hunterian lecture possesses special interest for Guy's men, associated as it is pretty intimately with the name of Sir Astley Cooper, "the leading learned and popular surgeon of his time." Professor Keith seeks to establish the genuineness of the alleged Napoleonic relics, and at the same time throws much interesting light on the question of the disease which carried off the French Emperor. The relics in question consist of two small pieces of bowel, each of which shows a small plague-like outgrowth on the surface of the mucous coat. Sir James Paget, in revising the catalogue of Sir Astley Cooper's Museum, came upon them; they were unpretentiously labelled, "Incipient Fungus in the Glands of an Intestine: Napoleon: Barry O'Meara to Sir Astley Cooper." He doubted their authenticity on various grounds, but chiefly because no mention is made of them in the official post-mortem report, and boldly described the nodules as "plagues of cancer." Microscopical examination has lately revealed the fact that the nodules are not secondary cancerous deposits, but merely enlarged Peyer's patches.

With regard to the history of the specimens, Professor Keith places implicit confidence in the accuracy of the Astley Cooper's labels. The great surgeon was in the habit of ticketing all his specimens and dropping them into a big tank with little ceremony to await future examination. The scant respect afforded to so important a relic should not, therefore, lead us to suspect that Sir Astley doubted their authenticity; he was too shrewd and conscientious an observer to deceive himself. In regard to the statement made in the official post-mortem report on the remains of Napoleon that the intestinal mucous membrane "appeared to be in a sound state," Professor Keith skilfully argues that the report must have been inaccurate, since a cancer so extensive as that of Napoleon *must* have formed secondary deposits. Furthermore, the Government wished to show that the hand of God and not the climate of St. Helena had killed their prisoner; so the doctors were too pleased with finding the cancer to investigate further in the cause of science. The argument is strengthened by a non-official report which describes such deposits. How the remains may be thought to have come into the hands of O'Meara and passed from him to Sir Astley Cooper is as fine a demonstration of argument from probabilities as one would wish to read; it is, perhaps, a little too convincing. In conclusion, the Professor makes it highly probable that Napoleon suffered from an affection akin to Malta Fever, which would account for the peculiar enlargement of the lymphoid tissue in the specimens. "It is an

open question whether it was the fever or the cancer which actually killed Napoleon. The best that can be said is that, whether in St. Helena or out of it, cancer would have ended the career of the great Emperor."

THE young medical man who leaves the Hospital for private practice sets forth on a journey full of uncertainties, and probably as much as any man living needs the advice of his seniors. Such matters as the rate of fees, professional etiquette, a sufficient, and not more than sufficient, supply of drugs and instruments, etc., suddenly loom large on the horizon. Only the experience of older practitioners can preserve him from many annoying and often expensive mistakes. Some time ago there appeared in this journal a valuable article dealing with the subject, and we had hoped it might stimulate some of our readers to contribute similar material. No single practitioner can cover the whole ground. Town practices and country practices must be considered—rich practices and poor. We would, therefore, venture to suggest to the older members of the Hospital who are in general practice that they will confer a very signal favour on the younger men by sending us such various information in the matter as they may consider suitable.

THE Research Defence Society has written to us that it has recently taken premises at 171, Piccadilly (opposite Burlington House), and has opened a Bureau for the Exhibition of Pictures and Specimens, and for the distribution of literature. The Society has now been founded five years, its object being "to make generally known the facts as to experiments on animals in this country, and the regulations under which they are conducted: the immense importance of such experiments to the welfare of mankind, and the great saving of human and animal life and health which is already due to them." We believe the exhibition attracts a good deal of attention. Probably among our readers there are few who need conversion to the cause of research, but from all accounts there is much of interest and instruction for the visitor of whatever persuasion he be.

WE trust we shall not be suspected of any disregard of the dignity of labour if we address a word to certain members of the Works Department who enter the wards and discharge their duties therein without previous removal of their headgear. It detracts not a little from the chaste appearance of the ward. Besides, it seems a little unfair that the surgeons and physicians should put themselves to the trouble of taking off their hats while the British workman remains covered. No doubt the cap is considered as much a part of the official impedimenta of the latter as his tool-bag, but for this very reason we shall consider the doffing of that cap a mark of especial favour, and esteem it the more precious.

WE very gladly draw the attention of our readers to the letter of Miss Mallandaine in our correspondence columns. In these days there is a growing inclination to limit charity to our own parish, town, or, at widest, to our own county: well-doing cannot escape specialisation. But we at Guy's will not fail to be influenced by the fact that the appeal comes from one who has worked here. Miss Mallandaine is too eloquent for the cause she has at heart for us to add anything; and we are sure that the appeal to her own Hospital will not go unanswered.

IT is with regret that we would call attention to the Nursing News of this number. The fact that three Sisters have severed, for private reasons, their connection with the Hospital is not to be lightly passed over. It is not possible for the lookers-on to adequately appreciate all that a really good Sister's work means for her patients, the wards, and the nurses. We gather from the number of women who are eager to accept such positions that it is work that more than repays the thought, sympathy, and energy that are expended upon it. So with our thanks for the past we tender our good wishes for the future to Sister Stephen for her coming work in India. Sister Cornelius, whose work as Night Sister and in Out-Patients, and also in the ward, has long been known to us. The Out-Patient Department must long en-

shrine the splendid organisation and courageous management of Sister Patterson. And so to all, farewell.

PREVENTIVE medicine has rarely had a more forcible, not to say militant, exponent than Sir George Turner, and the honour which His Majesty has now conferred upon him will be recognised by his many friends as an appreciation of a life devoted to solid unostentatious work, both in the mother country and in the South African Colonies. Turner's boundless energy, tramelled as it often was by petty local politics in the Hertfordshire districts, to which he was M.O.H., found some vent in his work at Guy's where his teaching was characterised by an originality that imparted interest even to dry statistics; but it was his translation to Cape Colony in the late nineties that provided him with adequate opportunities. Here he was intimately associated with Professors Koch and Kolle in the elaboration of reliable method for arresting the ravages of the dreaded rinderpest, and here it was that Lord Roberts, always on the look out for the best men, secured him for the administration of the sanitary service of the newly acquired Transvaal Colony. The part Turner played in his new sphere of action, and particularly his work in connection with leprosy, are matters of common knowledge. Bluff to the point of brusqueness, plain spoken to the verge of brutality, but above all, kindly, sympathetic and helpful, all who know Sir George Turner will join in congratulating one, who, for many years was, perhaps, the most striking personality at Guy's.

ATTENTION is drawn to the following notice posted in the College:—

> "This is to give notice that all unclaimed bicycles in the College will be disposed of after January 31st, 1913. It is requested that the owners will remove their bicycles from the College before this date, or else communicate with the Warden."
>
> L. BROMLEY,
>
> *December* 31*st*, 1912. Warden.

WE offer our congratulations to Mr. T. Evans on obtaining his London M.D. His name was omitted by mistake in our last from the number of those who have just obtained that distinction. Our congratulations are none the less sincere for being somewhat late.

Change of Address.

H. G. Crawford, M.R.C.S., L.R.C.P., from Guy's Hospital to the Infirmary, New Cross, Wolverhampton.

H. Dawe, M.R.C.S., L.R.C.P., L.D.S., from Guy's Hospital to 1, Wentworth Villas, Tavistock Road, Plymouth.

S. G. Floyd, M.D., from Lister House to Milton House, Orsett Road, Grays.

A. L. Gardner, M.R.C.S., L.R.C.P., from Poplar and Stepney Sick Asylum, Bromley, E., to Waters Meet, Ilfracombe.

Thos. Holmes, M.D., M.S. Lond., from 10, Queen's Terrace, Southsea, to 11, Imperial Square, Cheltenham.

Gerald Robinson, F.R.C.S., from 2, Mutley Park Terrace to 7, The Crescent, Plymouth.

Stanley Wickenden, L.R.C.P. Lond., M.R.C.S. Eng., from The College, Guy's Hospital, to "Glenside," Tunbridge Wells.

(*The Editor will be very glad to receive a postcard with notes of any change of address.*)

Papers by Guy's Men.

N. D. Bardswell, M.D. Edin.: Some Observations upon the Treatment of Pulmonary Tuberculosis, the Dose being regulated by Frequent Estimates of the Opsonic Index.—*Lancet*, 4th January, 1913.

Lawrie McGavin, F.R.C.S.: Cœcotomy for Removal of a Hairpin impacted in the Ascending Colon.—*Lancet*, 11th January, 1913.

E. F. Maynard, M.D., M.R.C.P.: Salvarsan in Pernicious Anæmia.—*British Medical Journal*, 11th January, 1913.

H. Knights Rayson, M.D.; Attempted Suicide by Drinking Lysol.—*British Medical Journal*, 4th January, 1913.

D. W. Samways, M.D., D Sc.: The Causation of the Crescendo Character of the Presystolic Murmur.—*British Medical Journal*, 11th January, 1913.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette." Guy's Hospital, London, S.E.*

Guy's Hospital.

IN accordance with annual custom the House-Committee publishes for the information of the Medical, Surgical, and Nursing Staff the following Tables showing the total number of patients sent during the past year to the various Convalescent Homes connected with the Hospital, and the amounts found in the Ward Collecting Boxes, together with Special Donations.

WARDS.	NUMBER OF PATIENTS. 1911.	1912.
Astley Cooper	37	37
Cornelius	22	27
Lazarus	53	60
Job	75	80
Naaman	41	32
Luke	52	46
Patience and Samaritan ...	57	42
Charity	54	59
Dorcas	42	58
Lydia	88	109
Martha	48	58
Eye Wards	24	15
Addison	70	59
Mary	55	40
Stephen	126	106
Esther	43	44
Queen Victoria...	40	48
Clinical	85	72
Isolation	—	1
Surgery	—	—
Out-Patients	67	68
	1,079	1,061

The subjoined list gives the distribution of the Patients amongst the various homes :—

Ascot Priory	149
Barnet (Children's Home Hospital)	4
Bexhill (M.C.I.)	54
Bognor (Merchant Taylors' Home)	21
Broadstairs (M.C.I.)	189
Cobham (Schiff Home of Recovery)	72
Didworthy (Devon and Cornwall Sanatorium)...	5
Holt (Kelling Sanatorium)	16
Rustington Convalescent Home	16
Shooter's Hill (Baroness d'Erlanger's Home) ...	22
Swanley (Parkwood)	244
Walton-on-Thames (M.C.I.)	79
Weybridge (Mrs. Vernon Carter)	18
Worthing (Miss Henry)	123
	1,012
In addition to the above, 49 patients have been sent, principally in co-operation with the Charity Organisation Society and the Invalid Children's Aid Association, to 33 different Homes for prolonged convalescent treatment	49
	1,061

List of amounts received from Patients in the various wards, and sums found in Ward Collecting Boxes, etc., for the year ending December 31st, 1912. The amounts received in the previous year are inserted for the purpose of comparison.

	Box Collections. 1912. £ s. d.	Special Donations. 1912. £ s. d.	Totals for 1911. £ s. d.
Front Gate Box ...	1 12 5	—	5 18 0
Porter's Lodge ...	8 9 6	—	21 2 10
Out-Patient Depart.	1 8 1	15 6	5 9 3
Surgery	8 0 6	5 0	13 18 8
Conservation Room	2 7 8	—	1 8 3
Actinotherapeutic Department	—	38 1 6	14 0 0
WARDS.			
Addison	16 10	8 1 0	14 11 6
Astley Cooper ...	2 1 6	12 17 0	22 14 9
Bright	3 16 3	1 1 0	9 2 8
Charity	5 4 2	15 0 0	23 6 8
Clinical	3 8 8	4 14 0	48 13 9
Cornelius	0 18 7	21 18 0	4 0
Dorcas	4 10 0	13 0 0	31 8 7
Esther	1 6 5	36 5 0	13 8 1
Eye	1 14 1	1 3 0	6 19 7
Job	5 0 7	10 3 0	27 14 6
Lazarus	2 11 6	23 7 0	27 12 8
Luke...	3 7 4	34 2 0	38 11 5
Lydia	3 7 10	10 11 0	22 16 8
Martha	3 18 6	65 9 0	20 5 4
Mary...	19 1	20 10 0	15 3 4
Naaman	3 16 0	34 17 0	44 8 1
Patience	1 2 5	10 0 0	15 0
Queen	7 0 9	20 6 6	50 16 3
Stephen	14 10	21 11 0	7 0
	£77 13 6	£403 17 6	£480 16 10

	£ s. d.
Total for 1912	481 11 0

January 1st, 1913.

Pass List.

University of London.

FIRST EXAMINATION FOR MEDICAL DEGREES.
December, 1912.

Anderson, G. N.	Heckels, G. W.
‡ Berncastle, H. F. G.	Joffe, J.
Bond, A. B.	Kidman, G. E.
Coombs, C. G.	Montocchio, J. O. R.
Elkington, G. W.	Phillips, E. S.
FitzGerald, G. H.	Traill, K. R.

Wong, S. T.

‡ Awarded a mark of distinction in Biology.

M.D. EXAMINATION.

The undermentioned was inadvertently omitted from the List published in GAZETTE on 4th instant :—

Branch IV.—Midwifery, &c.

Evans, T., B.S.

In Memoriam.

Eleanor Constance Laurence.

THERE passed to her rest on December 11th one of Guy's best known daughters—"Ella" Laurence, the daughter of the Rev. Percival Laurence, Rector of Walesby. She entered the Hospital in February, 1894, as a Lady Pupil. One still recalls her earnest and purposeful face and bearing, which marked her out amongst the other "new L.P.'s." These characteristics, added to previous experience—for she had already been a year at Great Ormond Street—made her promotion sure, and, after her training as Lady Pupil was completed, she was made a Sister. Her first charge was the Front Surgery, which never before had a Sister over it, and the task of getting the place into order and introducing economies into the administration was one after "Ella" Laurence's own heart. She records, with delight, that before she had been there a month the weekly cost of dressings was reduced by £7 to £10. Further experience was gained as Assistant Matron, Night Superintendent (there was only one for the whole hospital in those days), and then as Sister of "Martha" Ward. After three and a half years at this hospital, Miss Laurence went out to Egypt with a private patient, and while there had various adventures and a good deal of nursing. She was away between one and two years, and on her return went back again to Guy's as Sister. But her life's work was still before her. From the time she was a school girl her desire had been to join the Army Nursing Service; she had kept it steadily in view, and when the South African war broke out she volunteered for service. She tells graphically in her book, "A Nurse's Life in Peace and War," how fortune favoured her, and how she was selected—almost, as it seemed, by accident—as Lady Superintendent of Princess Christian's Hospital at Pinetown, Natal. Of her qualifications for the post there could be no doubt. She had been in South Africa before, knew its climate and ways, and last but not least, how to manage the native servant, while her innate gifts for administration and control had been developed and strengthened in a marked degree by her long and varied apprenticeship at Guy's. The history of her work in South Africa, which included in the middle a voyage to England in charge of a troop-ship, should be read in her own vivid narrative. She was mentioned in dispatches, received the South African War Medal and the decoration of the Royal Red Cross, and thus was fulfilled a resolve made nearly 20 years before in 1883, when grieving over being "only a girl," she determined she would try and win the Royal Red Cross which had just been instituted by Queen Victoria.

On her return to England in 1903, Miss Laurence was appointed Matron of the Victoria Hospital, Keighley. The work there was chiefly surgical, and one remembers the high level of efficiency to which she brought it. In 1906 she was made Matron of the Chelsea Hospital for Women, and to it with her went several members of her Keighley Staff. During the four years she was at Chelsea numerous improvements were made, and many are the nurses who have reason to be grateful for the thorough training they received under her firm and quiet rule. She resigned her post in December, 1910, owing to illness, and the last two years of her life were spent in a vain search for health, and the relinquishing, one by one, of all her active interests. It was during this time, however, that she published "A Nurse's Life in Peace and War," an account of her life, given in home letters, which had fortunately been preserved, from the time she first determined to be a nurse to the close of her stay in South Africa. The book has real literary merit, and it is probable that Miss Laurence would have made her mark in the world of literature, had she devoted her powers to it instead of to nursing. It should be read, not only by all those connected with Guy's, but by a far wider public, for it gives an extraordinarily interesting and vivid picture of a nurse's life in our large hospitals—of the experience of an intelligent and observant woman in various countries—and a most graphic narrative of different episodes in the South African War.

One of the things she mentioned with pleasure in the last weeks of her life was the kindness of one of her publishers, Mr. Reginald Smith, who, with his wife, often visited her during the months she was warded at Guy's.

She also wrote a useful text-book for nurses and was a frequent contributor to the best known nursing papers. Such is the bare record of the main facts of her life. One of the things that stands out in one's recollection of "Ella" Laurence was her many-sidedness. One felt instinctively that the welfare of her patients would be her supreme care, and that her work would be thorough and exact in every detail, but that for all this her outlook was not bounded by the four walls of her hospital. She was a first-rate horse woman, a keen tennis player, had a passionate love of travel, and took a keen and intelligent interest in things in general, while beneath her quiet manner there lurked a distinct sense of humour. Her life has ended when it seemed as if there were many years of useful and honoured work before her. She died (after months of illness at Guy's where every care was given her) in a nursing home of which Miss Rowell, the Lady superintendent, was an old Guy's friend.

Perhaps the strenuous time in South Africa undermined a constitution never very robust, but her life, if short, was full of work for others. She summed up her time in South Africa in the following characteristic words:—"I would not have missed nursing through this war for a great deal. We have often had rough times, and anxious times, and, of course, I have not been able to do much, but I have been able to help a few men to recover their health and strength; and, perhaps, also to help a few in their last hours—men whose own relations would have given much to have been in my place, where it was not possible for them to be, and however busy I

was, I could at least find time to remind them that . . . . 'God shall wipe away all tears from their eyes; and there shall be no more death, neither sorrow, nor crying, neither shall there be any more pain.'"

Surely to have accomplished this is to have accomplished much, and one can but rejoice that for her, too, that promise has come true, and that "her warfare is accomplished."

Guy's Hospital Dental Society.

A MEETING of the Dental Society was held on Friday, December 13th, at 4.15 p.m. Mr. Ernest B. Dowsett, the President, occupied the chair. The minutes of the last meeting were read and confirmed. Two casual communications were shown—one by Mr. Morrish, of a lower molar tooth with its roots curved directly horizontally to the crown; the other, by Mr. Bradley, of a model of a patient's mouth, who is firmly convinced that he has a polyphyodous dentition.

The paper for the afternoon was read by Mr. D. B. Morrish on the subject of "Dental Education." He followed the syllabus with relentless perseverance, allowing nothing to pass without some comment, usually of a dry and caustic nature. He seemed chiefly anxious to eradicate certain so-called futilities, to do away with lectures bearing on obscure subjects, to be replaced by demonstrations and courses of greater practical importance.

In the discussion which followed, Mr. Bulleid emphasised the great advantage of the medical degree He spoke scathingly of tooth-carpenters, and the narrowness of the Dental Syllabus. In direct opposition to the reader of the paper, he advocated more work and more time, and sat down at length leaving his audience with very mixed feelings.

Mr. Underwood, who continued the discussion, spoke quietly and to the point. He showed how difficult it would be for the Dental Board to revise in a radical manner its present regulations. The supply of dentists not being equal to the demand, it was quite unreasonable to suppose that any steps would be taken to lengthen the period of study for dental students.

Many men subsequently continued the debate, some advocating a new degree which should embrace everything that was to be learnt with regard to medical science, building up wonderful "Chateaux en Espagne," others revelling in picking previous speeches to bits.

The President wound up the discussion in a very able speech, which cannot be justly epitomised. His main contention, however, was that one should read widely and observe much—that a broad mental outlook was the thing to be aimed at, that the modern spirit of learning was often too materialistic.

Mr. Morrish briefly replied, and the proceedings terminated with a very hearty vote of thanks to the President.

London Bridge and the Borough in the Eighteenth Century.

(*Continued from page 16, new vol.*)

XV.

UPON A BISHOPRIC AND A BREWERY.

"*Arrogant Winchester, that haughty prelate.*"

. . . . . .

"*And for thy treachery, what's more manifest,—*
In that thou laid'st a trap to take my life,
As well at London Bridge as at the Tower?"

KING HENRY VI., part i.

Perhaps after so long a sojourn in the hospitals, the reader may prefer to make the first call at the Brewery.

Since the time when Chaucer's Miller in "The Canterbury Tales" thought it necessary to apologise in anticipation for any errors of taste that might be due to the "ale of Southwarke," the district has always been celebrated for its brewing. There have been many breweries situated along the Bank, and one especially has become famous. When first we meet it, it is known as Mr. Halsey's "Anchor Brewery," a name still retained by the little tavern at the junction of Bankend with Bankside. Halsey sold it to the elder Thrale, who died in 1758 after serving as Sheriff of Surrey and Member for Southwark. To him succeeded his son Henry Thrale, who has been immortalised by his friendship with the great Dr. Johnson. At his house in Deadman's Place, now Park Street, and at the villa at Streatham, Johnson spent much of his time from their first acquaintance in 1756 to the time of the brewer's death. The house by the brewery was destroyed by fire in 1832, but an armchair and other relics traditionally associated with the lexicographer are still preserved. Johnson's "Life of Congreve," and perhaps part of the famous Dictionary, were written in this house. Mrs. Thrale, "short, brisk, and plump," lived on the friendliest terms with the blunt old literary autocrat, who objected to her appearing in sombre garments; "What! have not all *insects* gay colours?"

Henry Thrale succeeded his father as Member for Southwark, but was rejected at the election of 1780, when he was already in failing health. He died in the following year, appointing his old friend as one of his executors. It was during a tour of the brewery before the sale that Samuel Johnson delivered himself of that famous pronouncement, "We are not here to sell a parcel of boilers and vats, but the potentiality of growing rich beyond the dreams of avarice!" Unless he was merely using the rhetoric of the auctioneer, the words testify to the foresight of the

speaker, for Thrale, after living beyond his income in his later years, had left the brewery £100,000 in debt, which was easily paid off by the establishment in nine years. Of the partners who made the purchase, for £135,000, Mr. Perkins had previously been manager of the brewery, and both lived to prove the truth of the prophecy. Dr. Johnson survived his friend for three years only. The widow, although 63 years of age and the mother of twelve children, in 1784 married a popular singer twenty years her junior, Gabriel Piozzi. She outlived her second husband, and died in 1821.

During the Gordon Riots the brewery was threatened by the mob, but was saved from destruction by the presence of mind of Mr. Perkins who, by broaching some barrels of porter, diverted the attention of the leaders.

The brewery again figures in history in 1850, when the draymen assaulted the Marshal Haynau, whose reputation as a flogger of women in the Hungarian War had preceded him in his visit to the establishment. Lord Palmerston, writing to Queen Victoria on the matter, ventured to inform her "that the name of 'General Hyæna' was given to him at Vienna long before it was applied to him in London."

Leaving Barclay & Perkins's Brewery by way of *Park Street,* and passing under the S.E.&C. Railway bridge, we find *Winchester Stairs* by the riverside, *Winchester Square,* across Clink Street, and, further south, *Winchester* and *Rochester* Streets. Our problem is to find a derivation for these names.

When enquiring into the origins of St. Saviour's Cathedral, we found that from its earliest days it has been associated with the bishopric of Winchester. That see, originally one of the largest in England, whilst comprising a great part of the South of England and the Channel Islands, included also Southwark and the rest of South London. At a redistribution in 1877 this district was transferred to the see of Rochester; until, in 1904, Southwark was constituted a separate diocese, and St. Saviour's was elevated to the rank of a cathedral.

The names have, however, a more precise association than that afforded by the ecclesiastical boundaries. The true sponsors were a couple of episcopal palaces that in former times stood in this neighbourhood.

Winchester House was a very large building occupying the site which now forms the southern side of Clink Street, and the present Winchester Square formed one of the ten large courts included by the palace. To the south and west of the building was a fine park of 60 or 70 acres, limited on the west by the line of what is now Park Street. The palace was built about 1107, "upon a plot of land pertaining to the Prior of Bermondsey," by William Gifford, the Bishop of Winchester, who founded the priories of St. Mary Overy and Waverley near Farnham. Like the priors and abbots of Hyde, St. Augustine, Lewes, and of Battle, already mentioned, the prior of Waverley had a town-house for his reception when parliamentary or ecclesiastical duties required his presence in London. Waverley House fell into the hands of the Brownes (afterwards Lords Montague) at the Dissolution. Yet another of these mansions was that of the priors of St. Swithin's at Winchester, upon the site where Rochester House afterwards stood.

Bishop Peter de Rupibus, Chancellor and Chief Justice to King John, occupied Winchester House at the time when he founded the hospital of St. Thomas. The famous William of Wykeham lived here after his succession to the bishopric in 1366, and at his death left bequests for prisoners in the Marshalsea and elsewhere, and money to the brethren and sisters of St. Thomas's Hospital that prayers might be said for his soul.

On a previous occasion we referred to the mansion afterwards converted into a public inn, whose name is still remembered in Green Dragon Lane, leading from Bedale Street to the Borough Market. A member of this family, Joan de Cobham, who died in 1369, in her will desired that she might be buried in the churchyard of "St. Mary *Over-the-re,* before the door where the Blessed Virgin sitteth on high." She, too, left money to the sisters ministering in St. Thomas's Hospital and for the sick persons lying there. Hers was the family which is commemorated by the magnificent sequence of monumental brasses in Cobham Church in Kent.

Henry Beaufort, the cardinal in Shakespeare's "King Henry VI.," was another occupant of Winchester House. His arms, borne as the son of John of Gaunt and Katherine Swynford—*within a bordure componée, France and England, quarterly,* surmounted by a cardinal's hat with its tasselled strings twisted into a true-lover's knot—still adorn the south transept of the cathedral. Within St. Mary Overy's was celebrated, in 1423, the marriage of his niece, Jane Beaufort, with James I. of Scotland, and in the palace afterwards, the wedding feast.

During his residence here in 1473, the cardinal caused a stone bridge to be built across a stream in Bermondsey Street; and at the time of Cade's insurrection he met the rebel in St. Margaret's Church, and succeeded in detaching some of his followers.

Fox, whose altar-screen has recently been restored, was bishop of Winchester from 1500 to 1528.

Bishop Gardiner was held a prisoner in the palace in 1551, and was still in occupation when Wyatt's rebels attacked the house and utterly destroyed his library.

Andrewes appears to have been the last bishop to occupy the palace, and after his time the building fell to baser uses. The Parliamentarians in 1642 converted it to a prison, and Sir Kenelm Digby, among others, was confined in it. At the Restoration it reverted to the see of Winchester, but Bishop Morley

leased the property, and so, says Rendle, "in course of time, *Red Cross Street, Queen Street* (now Quilp Street), *Duke Street* (Great Guildford Street), *Ewer Street, Worcester Street, Castle Street*, and others came to be," and the palace itself transformed to prison, workhouse, tenements, warehouses, etc.

In 1692 it had become a chapel for Particular Baptists, run by a group of Fifth Monarchy Men. Throughout the eighteenth century the palace fell more and more into a ruinous condition, until a fire in 1814 completed the destruction. There survived nothing but the shell of the great building and the remains of a great rose window, which was imitated in restoring St. Saviour's. Since that time even the ruins have perished.

In exploring the foundations, it was discovered that the palace had been built upon the site of a Roman villa, placed conveniently near to the southern point of the ferry to which the ancient Stoney Street led.

Rochester House was situated a little further westwards, near the river. The bishops of Rochester had had a house in Lambeth where is now Carlisle Street, behind St. Thomas's Hospital, which they occupied down to the time of Bishop Fisher, 1504—1535. In 1543—4 an Act of Parliament sanctioned the exchange of tenements between the Lord Admiral and the Bishop of Rochester whereby the latter obtained what had been the house of the priors of St. Swithin, in Southwark.

A bishop was still in occupation until 1558, although, when writing his Survey, Stowe says, "but well I wot the same of long time hath not been frequented by any bishop, and lieth ruinous for lack of any reparations." It was taken down in 1604, and by 1720 the site was occupied by small dwellings.

The name "Park Street" is not much above a hundred years old. Before that time it was known as Deadman's Place, whilst the western continuation of it (now Sumner Street) went by the name of Maid or Maiden Lane. Deadman's Place appears to have been so called from the numerous burials of victims of the plague in Tudor and subsequent times. An old burial ground, shown upon maps of a hundred years ago, is now absorbed into the brewery premises. As an alternative derivation, some have attempted to trace the name to "Desmond's Place," alleging that certain Earls of Desmond dwelt there.

Maid Lane has been said to have owed its name to one Jacob Meade, employed about the bear garden; but the lane had its name before the man.

Close to the line of Park Street, dividing the bishop's grounds from the pleasure gardens further west, the maps of the seventeenth century show a narrow stream spanned by numerous small bridges and furnished at one point with a permanent "cucking-stool." This instrument, also known as a tumbrel or trebuchet, consisted of a long lever bearing at its extremity a chair. The occupant of the chair, safely strapped in, could be ducked in the stream to the great enjoyment of the spectators and at no discomfort to them. It was chiefly employed in the treatment of "women that are scolds or are unquiet"; and its revival has been advocated, quite unofficially, in recent times. The last legal conviction of a scold occurred at Maidstone Sessions as far back as 1745. More than one pillory—to name another mode of punishment popular at that date—was to be seen in and about the Borough.

St. Saviour's Grammar School was founded by a group of parishioners about 1562, and Queen Elizabeth granted it a charter not many years later. Two of the founders, Thomas Cure, saddler to Edward VI., Mary and Elizabeth and William Emerson (from whom Emerson Street, leading to Bankside may be assumed to take its name), and two of the early governors, John Trehearne, gentleman-porter to James I., and John Bingham, saddler to Elizabeth, have all elaborate monuments within the cathedral.

Thomas Cure also founded a "college" or almshouse on the tenements of Waverley House in Deadman's Place. In the churchyard Mrs. Dorothy Appleby in 1681 instituted a free school. Near here was also one of the almshouses founded about 1616 by Edward Alleyn, of whom we shall have something to say later.

The original Grammar School was situated on the south side of St. Saviour's churchyard. It was burnt down in 1676, but immediately rebuilt, and among the contributions for the purpose was £500 from Dr. Heberden, who had been partially educated at the school. About 1840 the extension of the Borough Market was the cause of its removal to Maid Lane, afterwards renamed Sumner Street, in honour of Bishop Sumner, who, with Messrs. Pott (of the vinegar yard) had been chiefly concerned in establishing the school in its new situation. In more recent times the school has been amalgamated with that of St. Olave's, and shares with it the large buildings by the foot of Tower Bridge.

Prior to 1753 the Borough Market had been held in the High Street, from the bridge as far as the commencement of St. Margaret's Hill. It had become a nuisance to the traffic there, and new sites were suggested. In the year named, petitions were received by the Court of Common Council; one from the parishioners of St. Saviour's, against removing it at all; one from St. Olave's recommending Ship Inn Yard (immediately north of St. Thomas's Hospital) as a suitable place; and a third, from other inhabitants of St. Saviour's parish, suggesting a plot of waste ground (of which more hereafter) behind the Greyhound Inn Yard (now Union Street). The same Court first had before it the recommendation to erect a new bridge between that from Fish Street Hill and the Borough and Westminster Bridge. The proposition was assented to, and "the sticklers for a new bridge soon fixed upon the mouth of the Fleet-ditch to the opposite shore"—Blackfriars Bridge.

In 1755 an Act was passed to prevent the holding of any market in the High Street in the Borough of Southwark, and the final choice fell upon "a spot called the Triangle abutting on a place called the Turnstile on the back side of Three Crown Square or Fowle Lane or buildings in Rochester Yard and Dirty Lane and towards Deadman's Place."

(To be continued.)

Coli Infection of the Urine.

CLINICAL LECTURE BY W. HALE WHITE.

GENTLEMEN,—We have often talked about the subject of the bacillus coli in connection with the urine when we have been in the wards, and, therefore, I ought, perhaps, to apologise for taking it this afternoon for the lecture. My excuse is that the description in the books is very scanty, and so I hope it will not be time wasted if we go into the matter according to the light of the cases we have had recently. During the last nine months there have been four cases under me in the wards of bacillus coli infection of the urine, and, in addition, in one the infecting organism in the urine was the proteus. All these people, you will remember, were ill enough to come into the hospital. Probably there are many slighter cases, whose illness is not severe enough for them to come in; so it is a disease of some importance. All these cases who were under me were women, and one was pregnant, and another had been only recently confined, the illness having, it was clear, come on during her pregnancy. That serves to emphasise the fact that coli infection of the urine is much more common in women (especially if pregnant) than in men, and it is so in the proportion of about eight or nine to one.

Naturally, the problem which puzzles you most is, how do the colon bacilli get into the urine. As the disease is much more common in women than in men, it is natural to suggest that they pass from the anus across the perineum to the vulva, up through the urethra, and so the urine gets infected. There is some support for that idea, for at all ages, whether in children or adults, the females exceed the males in the proportion of 8·5 to 1. But there seems no reason why the organisms should be more prone to pass from anus to vulva in pregnant than in non-pregnant women, yet the opinion is universal that this condition is most common in pregnant women. Then, too, you must have noticed, in the cases I have shown you in the wards, that it is common to get a pyelitis due to coli infection of the urine without there being any evidence of cystitis. Yet if the organism were transmitted direct from anus to vulva, you would expect to find urethritis, then cystitis, and later, pyelitis. But it is not so; generally, pyelitis is the first and only evidence of infection of the urinary tract. And if the organism is transferred in that way, it is difficult to understand why bacillus coli infection of the urine is not universal in female babies, because they all have a great likelihood of transferring the bacilli by soiled napkins.

Another suggestion is that the organisms pass directly from the colon to the kidney. You will remember that the colon lies in contact with the kidney. Some figures were published in the *British Medical Journal* not long ago, by Dr. Ethel Williams, in which she tried to show that the urine was more infected with the bacillus coli in constipated than in other people, and she considered the organism passed from the colon directly into the kidney, and so set up pyelitis. But that is not in accordance with the facts obtained by other observers. Mr. Wallis, when he was my house-physician, took up this subject for his thesis, and examined the urine of 36 people, frequently going out of his way to choose those who were particularly constipated. One had previously had an ileo-sigmoidostomy performed, and another a gastro-jejunostomy, and they had constipation. But he could not make out that there was any relationship between the constipation and the infection of the urine. Various house-physicians have investigated twenty cases for me, examining the urine at random, so, altogether in my wards, 56 cases have been examined from this point of view, and in none of them could we trace any association between the state of the intestine and the presence of the bacillus coli in the urine, for, although many were constipated, in none was the bacillus coli found. What seems to me fatal to the view that the organisms pass through into the pelvis of the kidney from the colon is the fact that the proportion of female infants over male infants is the same as the proportion of adult females over adult males so affected. But no one will maintain that female infants are more constipated than are male infants.

It has been urged that the bacillus coli is taken up into the blood and is excreted by the urine. Let us examine that idea. Certainly, micro-organisms may reach the kidney by the blood stream; you all know that typhoid organisms may be excreted by the kidney. Let me remind you of other examples; there have been several in the hospital. A woman who was under me, æt. 50, had some acute arthritis in several joints. We found pyorrhœa of the gums. We examined her urine, and both urine and gums gave us the pneumococcus. There

was a better case in No. 8 bed in Clinical, that of a boy who came in with lumps about him, which finally suppurated. He had not got glanders. All that we could find as giving an explanation were two little hairy follicles on the inner side of the thigh, which were inflamed. If he had been well, no attention would have been paid to these follicles. He was obviously very ill, and we examined his urine, and found in the urine staphylococcus aureus; and, later, that organism was discovered in the blood. But the first specimen of his blood did not show it at all. We turned our attention to these inflamed follicles on the inner side of the thigh, and they contained the staphylococcus aureus. So the organisms were found in the urine before they were found in the blood. It is suggested in these coli cases that the micro-organisms are conveyed to the urine by the blood, and that appeals to me more than any other explanation that I know. But the great objection is that people have frequently looked for them in the blood, but failed to find them. Dr. Williamson states that the blood has been found to be sterile in pregnancy cases in which, nevertheless, the bacillus coli was found in the urine. But the explanation of that difficulty, I think, is to be found in the *Lancet*, of two weeks ago, in which some observations are recorded on this subject, to which I direct your attention, in a paper by Messrs. Panton and Tidy, from the Laboratory of the London Hospital, and they have been fortunate enough to find the colon bacillus in the blood. They record three cases. I need not weary you with all three, but this is the third one. A woman, æt. 40, was admitted into the London Hospital. She had been confined five weeks previously. She was quite well until the tenth day after confinement, and then had several shivering attacks. On admission she looked very ill, and had a high temperature and rigors. A culture was made of the blood during the rigor, and all the tubes yielded a growth of the colon bacillus, a pure culture. I want you to note that the culture was made during a rigor, and since I read these notes it has occurred to me that the probable reason why the colon bacillus is so difficult to obtain from the blood in these cases is, that it may only be present in the blood in sufficient quantities to be detected when the rigor is occurring. So, in the face of this communication, I doubt whether the statement in the books that the blood is sterile in most of these cases is worth much, unless the author says the cultures were made during a rigor. Panton and Tidy suggest a direct relationship between the occurrence of the rigor and the entrance of the organisms into the blood in large quantities. So, although, I am afraid, we must regard the matter as unsettled, I think that, on the whole, the most likely view is that in these cases of coli infection of the urine, you have got the blood infected with the colon bacillus, but not in sufficient numbers to be detected unless there is a rigor in progress.

To turn back to the more clinical part of the subject, you know in 80 per cent. of the cases the infection is in the right kidney only. I do not know why. As I have said, it is thought to be commoner in pregnancy, but I do not know of any definite figures on the point. The following ingenious explanation has been advanced for its more frequent occurrence in pregnancy. You know that the uterus, as it ascends in the pelvis during pregnancy, presses on the ureters. If you make a post-mortem on a woman at the eight month of pregnancy you find that the ureters and the pelves of the kidneys are both somewhat dilated. And the right ureter is more pressed on than the left, owing to the fact that as the uterus rises out of the pelvis it rotates through part of a circle, and the larger part of the uterus presses on the right ureter; and again, that this pressure is mostly felt about the sixth to eight month, because, before that, the uterus is not big enough, and after that it has risen well out of the pelvis. At first sight that seems satisfactory, because women often show the colon bacillus in the urine about the seventh month, and the trouble is more common on the right than on the left side. But, again, we are face to face with difficulties, and I do not think we have got to the bottom of the matter in that explanation, for in the cases you see in the wards, even in women who are not pregnant, the trouble is more common on the right side. You must also remember that this explanation, although it may appear to account for it being commoner on the right side, makes no attempt to explain how the micro-organisms reach the blood. And the condition is not specially frequent when the pregnancy is complicated with a uterine tumour, such as a fibromyoma, yet you would expect it to be so on this pressure theory. So we must leave it that we do not understand how the micro-organisms get into the urine, though probably they get there *via* the blood, which is most natural; but yet we do not know why the condition is commoner in pregnancy, nor why

it is more frequent on the right side than on the left.

The next thing to talk over is the symptoms. The first is pain. In the large proportion of cases the patient complains of pain. It is usually a local pain, and I think the cases which have given most difficulty in diagnosis are those where the pain comes on suddenly, so simulating that of renal calculus. For example, a woman, æt. 51, had had pain in the bladder, pain on micturition, occasional feverish attacks, with pus and blood in the urine, for four months. The diagnosis of vesical calculus was made. X-rays and the sound, however, both failed to find a stone. The urine was found to be swarming with the bacillus coli, and she got well. Another woman had pain in the right renal region and frequent micturition. Bacillus coli was found in the urine, and she got well. Some months later she had another attack of pain in the right kidney, and was seen by the same doctor who found the bacillus coli before; but the pain in the kidney was so like that of renal calculus that he thought it must be due to that, and so sent her to be radiographed. But it was found to be due to infection of the urine. Here are particulars of a case admitted under me. A woman was seized with sudden pain, exactly like that of colic due to a calculus in the right renal pelvis. The pain doubled her up, and she was brought straight from her work to the hospital. By no means could we find stone, but the urine contained plenty of the bacillus coli, and treatment directed to that cured her. There are all grades of pain, from that which is so severe as to double the patient up, to a mere belly-ache. These patients often say they have got lumbago, and when the pain is severe there is a good deal of rigidity and tenderness over the kidney; these are the earliest symptoms.

It may hardly seem likely that these cases could be mistaken for appendicitis. But some of you may remember the woman, æt. 28, who came in one Saturday night last spring, having been sent up by her doctor with the diagnosis of appendicitis. She complained of pain and tenderness on the right side of the abdomen, and had pyrexia. Mr. Mutch found a trace of albumen in the urine; he had been very interested in these coli cases, and decided to leave the patient for a time. She became better on Sunday, and on Monday, too, but the temperature rose again on Tuesday. The only point, up to Monday morning, against the case being one of appendicitis was that the pain was a little further up than in appendix cases usually. Although we knew she had a trace of albumen in the urine, and by Monday afternoon cultures revealed the bacillus coli, the pain, rigidity, and tenderness were so near the appendix region, that on Tuesday Mr. Steward and I, remembering the risk which would be run by not operating if she had appendicitis, decided she should have the appendix out. But it was found to be perfectly healthy, even under the microscope. The subsequent history of the case showed it was purely one of coli infection of the urine. In thin people with coli pyelitis you may sometimes feel the kidney enlarged. Especially remember that they complain of frequent micturition. You should, in a case of frequent micturition, or in one of frequent wetting of the bed at night by children, always thoroughly examine to see whether it is a case of bacillus coli infection of the urine; micro-organisms are a not uncommon cause of incontinence of urine. The swollen kidney, frequent micturition, and incontinence are not so frequent as the pain and tenderness over the kidney.

The urine is slightly turbid, and you would expect to find much albumen in it, but it is surprising how small a quantity you often do find; indeed, there may be none. As you know, it has a characteristic fishy smell. It is usually pale, acid in reaction, and, if the infection is acute, it may contain blood. I do not know that any particular point here may lead you astray, except the blood, and that may well do so. Last summer there was, in Mary ward, a woman who had had scarlet fever when she was 40, and she came in with thickened arteries and a high-tension pulse, a hypertrophied heart, and albumen in the urine. While she was in she had several attacks of hæmaturia. I had always believed and taught that the cause of hæmaturia in such a condition was that the patient bled from the urinary tract, just as they do into the brain or nose. But we examined her urine and found it to contain plenty of bacillus coli, and I think it is very likely that the bleeding had nothing to do with her high pressure, but was due to the bacillus coli. Those who have been my clerks know that we have been interested in the hæmaturia sometimes seen in relation with pneumonia, and until the last few months I thought it was due to the pneumococcus setting up a pneumococcal nephritis. Yet, in each of those

cases we examined we found it was due to the colon bacillus. In any obscure case of hæmaturia you must look for bacillus coli in the urine.

Now, with regard to the general symptoms. They are of all degrees. Indeed, some people have said you may find the bacillus coli in the urine in people who have nothing the matter with them. If that is true, it is very important; because if they have these bacilli normally and then they come before you with certain symptoms, you may not be justified in attributing those symptoms to the organism. It was with that in view I asked men who have been my house-physicians to get a large number of urines examined. As far as we could make out, from the 56 cases we never found the bacillus coli in the urine unless there was something in the clinical aspect of the case to direct our attention to the possibility of the patient having the bacillus coli in the urine. If the patient is severely ill, the general symptoms are very marked; they are, high temperature, rapid pulse, rigors, sweats; that is, bacillus coli septicæmia. Remember the general symptoms of the case in which it was thought that the patient had appendicitis, but really had coli pyelitis. There may be a considerable temperature due to bacillus coli infection of the urine. Not long ago I saw a woman who had this infection, with a small impacted calculus in the ureter. The temperature went up to 104°; she was sweating profusely, and had a severe condition of septicæmia. Sometimes these people are sick. Renal calculus cases, too, may be sick.

Here are notes of some cases that illustrate the symptoms; they all had bacillus coli in the urine. A woman, æt. 38, was admitted under me with the history that for the past fortnight she had had to pass her water more often than she used to. She had passed blood, and had had great pain in passing water.

Here is the case of a woman, æt. 29, who was admitted under me, and her chief symptoms were a dull aching pain in the small of the back and on the right side; and the pain extended round to the front of the abdomen, and was intermittent. She had been told she had rheumatism.

Here is a very good case which is in the hospital now, and illustrates the points very well. In March this year, when five months pregnant, she was admitted with pus, blood, and albumen in the urine, and also the bacillus coli. She went out, and was re-admitted under me forty-eight hours after her confinement, and the report says: "Yesterday morning she was admitted with a temperature of 102°, and a pulse of 140, respirations 32. She now complains of pain and tenderness on the right side of the abdomen; the pain is increased by any movements. There is slightly increased frequency of micturition, but the act is not painful. The urine contained some albumen, and both blood and pus; there were a few pus cells seen under the microscope."

There are very few complications. Occasionally the inflammation proceeds to the formation of pus, and then very rarely there may be pyonephrosis or purulent cystitis, but they are not severe. Occasionally there may be some pleurisy.

With regard to the prognosis, that, in the case of the mother, is usually good. But obstetricians say the trouble may lead to abortion. You remember that the patients we have seen in the wards were discharged feeling very much better, and that you do not see this disease in the post-mortem room.

I have already said that the diagnosis from stone is sometimes difficult, and bleeding in the urine may cause trouble in diagnosis. And there are other difficulties in diagnosis, of which this is one. I saw a woman once last summer, and she had had, the previous year, slight rises of temperature in the evening, and some sweating, and she was not well. It was considered that she might have phthisis at one apex, so she was sent to winter in Switzerland, though she could ill afford to do so. While there she was repeatedly examined for tubercle bacilli, but none were found. When she returned to this country she still had slight evening rises of temperature, and sweats, but no physical signs of phthisis could be found. But her urine was swarming with the bacillus coli, and I have no doubt her whole illness was due to that. Not infrequently these cases are set down as subacute nephritis. For example, there was a woman who had pyrexia, which was attributed to influenza. Then the temperature gradually fell, blood was noticed in the urine, there was some albumen, and it was thought that she had acute nephritis. Blood persisted, and it was thought she had stone, but cystoscopy and X-rays did not reveal stone. At last the urine was examined bacteriologically, and was found to be swarming with the colon bacillus, and treatment for that got her well. There is a child whom I have seen, on and off, for a long while. When $4\frac{1}{2}$ years old that child caught a

cold, which was said to have got on the kidneys. Since then she has at times passed blood in the urine, and it has been regarded as subacute tubal nephritis, with occasional exacerbations. Her urine was found to be swarming with colon bacilli, and I think all her trouble was due to that. The way to avoid mistakes in diagnosis is to always bear in mind the possibility of this bacillus coli being in the urine.

With regard to the treatment of these cases, there are some who say they will get well if you leave them alone. I do not know whether that is true or not, but it seems worth while to try to do something for them. And I think the best thing you can do for them is this: First, flush the kidneys thoroughly. Give plenty of barley water and other bland fluids, so as to get rid of the organisms through the kidney as quickly as possible. Secondly, try to disinfect the urinary tract, for the local tenderness in the kidney region, the fact that the kidney is sometimes swollen, that there is sometimes pus, sometimes blood in the urine, and the frequency of micturition, point to the fact that the organisms are producing local symptoms in addition to those due to general infection. Therefore, you know I am accustomed to put these people on urotropine, and give acid sodium phosphate, 10 grains every two hours, to keep the urine acid, for we know that urotropine acts best when the urine is thoroughly acid. Sometimes washing out the bladder is recommended. That is distressing to the patient, and you run the risk of introducing fresh organisms. It has the further disadvantage that it is no good, for I have told you that it is very rare for the bladder to be infected by the trouble; it is usually a pyelitis, and it is for this reason that it is recommended to wash out the renal pelvis of the affected kidney through a uretal catheter.

These people are generally vaccinated, and it is difficult to know whether it does them good or not if the disease tends to get well of its own accord. Still, I have never known the vaccination do harm, and sometimes I have thought it helped the improvement. Here we generally use an autogenous vaccine, giving it in doses of 30 to 50 millions, at intervals of a week. Though when they leave the hospital these patients appear well, yet their urine usually still contains some coliform organisms, and that is thought to be a proof that they are not cured. But bacteriologists tell us it means that the colon bacillus is very variable, and those passing out at the close of the illness are not of the same variety as at the beginning; and that the right thing is to treat them with a different vaccine, according to the stage of the disease; *i.e.*, make a fresh autogenous vaccine about every three weeks, and use that. But be that as it may, when they have been under treatment they are usually completely relieved of their symptoms, even if coliform organisms are still present in the urine. Please remember that operation is scarcely ever necessary; I have known forgetfulness of that fact nearly end in disaster. A young fellow had typhoid fever, and, a few weeks after, he had pain, a swollen kidney, and pyuria. I was asked to see him because a surgeon said he proposed to explore and drain the kidney, and the father thought he would like somebody else to see him before that was done. I saw him, and found it was a case of ordinary colon infection of the urine, and he got well without surgical treatment. That is the only time I have seen the question of surgery raised for the condition. When women in pregnancy are very bad with it, having rigors and so forth, you may wonder whether you ought to induce premature labour. But they are no better for so doing.

When you are collecting urine for the examination you must collect it aseptically; collect it into a sterilised bottle by means of a sterilised catheter. Sometimes patients object very much to the use of the catheter. In male subjects it will sometimes suffice if the orifice of the urethra is cleaned up, a few drops of urine passed into the chamber, and the rest of the stream into a sterilised bottle.

I want to remind you about the importance of the subject in children. From time to time, as you know, we get children in who are very ill, and we do not know what is the matter with them. Sometimes their ilness is due to the bacillus coli in the urine. Here is a series of 60 cases from Great Ormond Street: 53 girls and only 7 boys. The symptoms may be very severe, and there may be quite a high temperature, and although rigors are so rare in children, these children may have rigors, and you may think that child has meningitis. If in a small child there is a temperature, perhaps rigors, perhaps delirium, with squinting and many nervous phenomena, it is your duty to examine the urine, for some supposed cases of meningitis are due to coli infection of the urine.

Historical Notes of Guy's.

BY FREDERICK TAYLOR, M.D.

II. A Lecturer on Botany.

In the "Educational Supplement" of the *Times* of Tuesday, July 2nd, was a section headed "From the *Times* of 1812. Education a hundred years ago." The second paragraph is as follows:—

"Botanical Lecture.—Doctor Thornton, Member of the University of Cambridge, and of the Royal London College of Physicians, delivered, on Monday, his introductory lecture on Botany, in the Philomathic Rooms, Burton-street. Much expectation was excited by the novel introduction of magnified flowers in the form of transparencies. They were received by a very elegant and numerous audience with a thunder of applause, repeated in bursts at each exhibition, and thus pleasure and instruction have at last become united."

There can be no doubt that this lecturer was the Dr. Robert John Thornton who lectured on Botany at Guy's Hospital, and whose connection with the hospital is described in "A Biographical Memoir of Guy's Hospital," by Sir Samuel Wilks and Mr. Bettany, 1892, page 427.

It is not clear for how long he lectured at Guy's. Wilks and Bettany say that he gave lectures here about 1804, but the folio frontispiece of his large work, to which they refer, is dated 1799. It bears his portrait, "Robert John Thornton, M.D., Public Lecturer on Medical Botany," and the drawing of Guy's Hospital which is reproduced in Wilks and Bettany's book, so that it seems he must have been lecturing at Guy's Hospital much earlier than they represent. His immediate predecessor was Sir James Edward Smith, founder of the Linnæan Society, and author of the text of the well-known Sowerby's Botany. Dr. Thornton's large work on the "Sexual system of Linnæus" was published in 1807, and he was still lecturing on Medical Botany, as the *Times* stated, in 1812. But Thornton was not only a botanist, he was a physician, and a Guy's man. He appears to have been born about 1768, and he went to Cambridge in 1784, where he eventually took his doctor's degree. The only entry that I can find in the records of the Medical School Office bearing upon his studentship at Guy's is as follows:—"John Thornton, December 18th, 1793"; but he is stated elsewhere to have had a three years' course.

In 1796 he published a book on the "Philosophy of Medicine," in 1797 he was practising as a physician in London, and he was for four years physician to the St. Marylebone Dispensary. He died in Howland Street in 1837.

Two questions remain: One, did the world really have to wait till 1812 before anyone had succeeded in combining pleasure with instruction? The second, Where were the Philomathic Rooms? So far, I have been unable to find any trace of a lecture hall having existed in Burton Street, which is a small street near St. Pancras Church. At that date it had only been built a few years, and consisted of residential houses of uniform and very moderate size.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—ED., G.H.G.]

DEAR SIR,—Dr. Kennaway had done good service to every student of medicine by calling attention to the subject of growth. Perhaps you will excuse my adding a few more "scattered notes" on the "innumerable aspects" of the subject. Probably the great number of aspects accounts for the fact that the subject is rather neglected by all teachers of physiology. It cannot be dealt with concisely in any lecture or class, and all the physiology that most men acquire is needed before the subject can even be touched upon.

The more one thinks of it, however, the greater its importance appears in the everyday life of the doctor.

1. "Growth with differentiation" is far more "discontinuous" than is "growth without differentiation." The former is seen chiefly at two stages of life: fœtal life, particularly during its first part, and again at puberty. The phylogenesis of our race is epitomised in the first four months of fœtal life; at puberty the individual passes from the child to the adult. In the child sex is a matter only of form; in the adult it become part of the life of the organism.

2. "Growth without differentiation" may be looked upon as the preparation for this change to adult life. In no part of the body does it occur without changes in the relative relations of different parts. These changes in the relative relations are most marked in the axis of the body, but also occur in the growth of the limbs.

3. The metabolism of the child differs from that of the adult. In the latter, anabolism merely has to

balance katabolism; in the former, it balances katabolism and supplies the new material necessary for added tissues. Associated with this is the wonderful power of repair in a child, and its rapid recovery after a severe illness.

4. The essential difference between the two sexes lies in this question of metabolism of growth. Once the male has acquired the adult metabolism, he retains it for the rest of his life. The female retains the power of returning to the metabolic condition of childhood during recurring periods, in the case of human beings, for another thirty years. During these times she acquires also the power of repair of a child. This may explain the great therapeutic value of pregnancy.

5. The change from the period of growth to the adult state is, however, no absolute one, as is shown by the following facts:—

a. As Dr. Kennaway mentioned, there remains a "capacity for growth during adult life." He instanced the epidermis and the red blood cells. The eruption of a wisdom tooth late in life when one of its proximal molars has been extracted is another example. Again, the development of brain power continues for many years during adult life, and although we do not know yet what they are, this probably is associated with changes in the structure of the cerebrum. Indeed, it is possible that the skull itself may continue to grow. The sutures of the skull of Fuchs, the mathematician, were found still to be open when he died at the age of 80.

b. Potential powers of growth remain throughout life in most tissues. The epithelioid cells of the periosteum remain as facultative osteoblasts. The same is shown by the hæmoblastic and leucoblastic changes seen in the yellow marrow of the long bones which occur in various diseases. Indeed, the repair of every wound exemplifies the same fact.

c. The stages of childhood and adult life overlap in the period of youth. Puberty occurs at 15, and the full stature may not be attained till 25. During this time the male may beget many children, and the female become pregnant on several occasions; she then retains her own power of growth while acquiring also the secondary power inherent in her sex.

There has been recently in your columns some discussion on the material which the general practitioner keeps shut up in his own brain for want of opportunity to publish it.

In growth he has a subject to our knowledge of which he might add many important facts. He often sees into the world the children of those whom he was the first to look upon. Any records of the periods of childhood and youth in which marked growth occurs would be valuable. The relations of these periods to illnesses and mental development are vaguely spoken of, but exact records of such things are wanting. Ages at which memory first develops in children might be recorded by others than parents, so that the fallacy of natural pride may be excluded. Perhaps some mute, inglorious Darwin has been storing up such things in the notes of a life-long practice. If so, let us beg him to bring them into the light of day.—I am, dear Sir, yours sincerely,

T. B. LAYTON.

48, Queen Anne Street, W.
January 7th, 1913.

DEAR MR. EDITOR,—Will you print the following appeal for me in the GUY'S HOSPITAL GAZETTE? I think, apart from the fact that it comes from one who herself owes much to Guy's and received her training there, it should speak with some force to all who are engaged in the great battle with ignorance and disease. More especially should it appeal to those who wage that warfare under the most favourable conditions, in a hospital where they have everything modern science can devise to arm them for the fight.

The object for which I have come home to plead is—to help to build a hospital for Europeans and Natives in Zululand, where more or less the Native people of the land are a prey to the most cruel and degrading superstitions. All misfortunes and disease they ascribe to the influence of evil spirits, and their belief in the occult and in the mysterious effects of medicine puts them into the power of medicine-men and witch doctors.

I have been working in South Africa for ten years, and even in that short time can see a great change in the natives. The people themselves demand education and all that it brings with it. The Government of the Country are raising the standard of education, and in accordance with this fact the Bishop of Zululand is centralising at Kwa Magwaza, and establishing there schools for boys and girls, as well as a normal college for training native teachers. This scheme involves a hospital, and so our hospital at Etalaneni is closed and we hope to reopen it at Kwa Magwaza as soon as the necessary buildings can be got ready. Kwa Magwaza is a much more accessible place for the hospital. Transport is easier and less expensive, and there is a still greater advantage in the fact that a doctor lives at the nearest magistracy only six miles distant.

The most advanced and best natives desire further improvement. They want to sleep on beds, to eat with decency and to cloth themselves well and becomingly. With this steady advance going on from an educational point of view, is it conceivable that the hospital should lag behind and continue its nursing in mud huts, the floors smeared with cow dung, and the patients lying on mats? The very word "hospital" suggests space and airy rooms, dedicated severally to special purposes, be it office, ward, surgery, dining-room, etc. But, at Etalaneni, where for six years the work was carried on, there were none of these as you picture them. The natives were nursed in a hut devoid of either window or chimney. When an operation was to be performed, if the day were cold or wet, a big fire had

to be made on the floor some time beforehand in order to let the smoke clear away and leave only the hot ashes, and the surgeon had to do his work by such light as could come through the door-way. If the natives were very ill and required a night-nurse, we turned out of our only sitting-room which was also dispensary and dining-room in one, and nursed the patient there.

In the hut with the sick person would live as many of the relations as could not be induced to go away. Take the case of a baby on a milk diet: if left for a moment, a mother or grandmother seizes the opportunity to force coarse porridge, beans, or pumpkin, etc., down its throat. Or another baby very ill with pneumonia and encased in a cotton-wool jacket, is found at dusk being held up naked by the mother in a cold, drizzling rain "to cool its hot body"! This sort of thing will be impossible when we have our native wards.

The verandah between our European ward and the rest of the building was a very patched up piece of work, and when there was a storm of rain of any force the place was flooded and all communication between the two parts cut off, until the water had been bailed out or swept away.

The side of our work which touches the colonists in lonely isolated districts must surely appeal to all their fellow-countrymen at home. Think of the hardships to be endured by a white woman nearing her time if she is obliged to take a long, costly, and rough journey to get medical care and nursing; often, too, she does not know what to do with her other young children during this enforced absence. We feel that this European side of the work is most important, and we lay ourselves out, not only to help the mother, but to take in the older children and their native attendants as well. As a rule, they are able to pay for their accommodation, though a case is never refused for lack of means. One young woman in great distress appealed to us for help. The horse was sent with a trusty native to meet the patient. She came a two-days' journey, the horse being led all the way; two hours after her arrival the child was born. After her recovery we were able to give her a fresh start in life, and she is now doing splendid work.

The money needed to build the new hospital at Kwa Magwaza is £2,000; for the nurses' block, £500; European block, £500; native block, £500; out-patients' block, £500. It is hoped that at least £500 will be raised before we leave England on March 8th, to enable us to build one block and to begin work at once. Of this sum we have £250 in hand.

If every one at Guy's would give even a small contribution towards our building fund, the total amount would take us a long step forward on our difficult road.

Sister Lydia has most kindly consented to receive and acknowledge any donations or subscriptions, and to send them on to me.—I am, yours truly,

LUCY MALLANDAINE.

The Editor regrets lack of space compels him to hold over till the next issue an account of two meetings of the Debating Society, and a letter dealing with the insufficient support accorded to the Society by the Hospital generally.

Some Further Therapeutic Points.

An Address read before the Aldershot Medical Society on Friday, November 1st, 1912, by

HERBERT FRENCH, M.A., M.D. (Oxon.), F.R.C.P. (Lond.).

MR. PRESIDENT AND GENTLEMEN,—The points that I hope to discuss this evening constitute a continuation of a paper read before the Woolwich Medico-Chirurgical Society at Easter this year, and published in the *Medical Press and Circular*, May 1st, 1912. As on that occasion, so now I must apologise if the different parts of it seem to you too disjointed. The different therapeutic points that I wish to bring before you have no connection with one another; many of them are far from new, but I think they all merit attention on account of their utility in practice. The first point is:—

The Value of Adrenalin Chloride applied locally in the Treatment of Graves' Disease.—There is probably no malady in which a greater diversity of treatment has been and is adopted by different authorities; in no malady is the probable course of the disease and the ultimate prognosis in any particular case more difficult to assess; in no malady, therefore, is it more difficult to convince oneself and others as to whether the treatment that is adopted is itself really doing good or whether the improvement would not have come about equally well if other measures had been adopted, or even no measures at all. Nowadays I suppose the first thing which has to be decided in one's own mind is whether one should advise Kocher's operative treatment as a routine or not, and every man must formulate his own opinion for himself upon this point. If I were to place myself in the position of a patient suffering from ordinary Graves' disease, and my medical man were to advise me to have it treated by removal of part of the gland, I should not be content with his telling me that a great many patients are cured by the operation, I should want him to be able to say that I was almost certainly not one of the kind likely to succumb to the operation itself. Now, so far as I have been able to judge there are no criteria yet known by which we can say that any particular individual suffering from Graves' disease can certainly be operated upon without the risk of death soon after the operation, apparently from fulminating thyroid poisoning or something of that kind. This being so, if I were the patient I would rather have other measures than surgical ones tried in the first instance. Amongst those which have done undoubted good in many cases may be mentioned the use of the X-rays locally to the gland; various forms of electrical treatment, particularly the interrupted galvanic current, one pole of the battery being over the thyroid gland region of the front of the neck, the other over the upper dorsal spines posteriorly; and simple treatment by rest in bed and feeding up without the administration of any particular drugs. The great value of rest in bed and a liberal dietary in acute cases is well known, but it is seldom possible to continue the rest in bed until a stage even approaching cure has been reached. As a rule, the rest can be continued

until the acute progress of the malady has been arrested, but presently the patient has to be allowed up notwithstanding the fact that the disease is still present, and then it is that the practitioner in charge of the case finds the need of resorting to all kinds of remedies and different therapeutic measures in the hope of making the malady retrogress still further. The number of different drugs that have been given internally to patients who have become much better or even perfectly well post hoc, if not procter hoc, is very great, so great, indeed, that it seems likely that the drugs themselves were not the cause of the recovery. The use of the milk of thyroidectomised goats, or the oral administration or hypodermic injection of serum from similar animals, has proved disappointing in practice. Treatment by the injection of hot paraffin or boiling water into the gland in the hope of causing some of the parenchyma to atrophy as the result of the inflammatory changes so produced has not yet been given a very general trial. I have not space here even to quote all the various other lines of treatment that have been resorted to. I should like to mention one in particular, however, which, though it may not relieve all cases, has certainly seemed to be the direct cause of the improvement in some who have previously resisted a large number of other kinds of non-surgical treatment: and this is by means of the local application of a solution of adrenalin chloride to the neck over the region of the thyroid gland.

My attention was first drawn to it by my friend, Fleet-Surgeon Dawe, but I am not sure whether I use the preparation in the same way that he did in his cases. I employ the ordinary solution of adrenalin chloride in the strength of 1 part in 1,000, applied on a piece of ordinary lint folded double and of sufficient size to cover the front of the neck from the hyoid bone above to the top of the manubrium sterni below, and extending laterally to a line drawn vertically downwards from the ear on each side. Just enough of the solution is used to moisten the lint without making it drip; there is probably no reason why more of it should not be employed at a time if it were not for its expense; the cost, indeed, is the chief objection to the treatment. There seems, again, to be no reason why the lint thus steeped in adrenalin chloride solution should not be renewed twice or three times in the twenty-four hours and applied continuously, but as patients who are up and about do not, as a rule, like applications to their throats during the daytime, one's ordinary habit is to prescribe the application at night only. The lint is covered with gutta-percha tissue, and the latter kept on with a suitable neck-band or bandage. It is generally advisable to pin the latter to the neck of the nightgown so as to prevent the whole application from twisting round the neck and becoming altogether displaced from the thyroid gland region during the night. As a rule, one also prescribes extract of malt and iron in two drachm doses three times a day. The type of malt and iron that I personally prefer is that which is made up by dissolving 2 parts of pyrophosphate of iron in 3 parts of water and then mixing this with 95 parts of thick dark extract of malt.

It is impossible to give statistical proof of the value of this treatment. One is obliged to be guided by personal opinion, and I quite agree that this is unsatisfactory because one cannot help being biassed. Nevertheless, from experience both in the Out-Patient Department of the hospital and amongst others who are better-to-do, one can assert with certainty that no ill effects accrue from it, and that so far one is strongly of opinion that the patients tend to increase in weight, diminish in nervousness, and to improve in general health under this treatment even when other measures have been tried and have failed; and amongst Out-Patients this applies even to patients who, on account of the need to continue earning a wage, have been unable to rest up in bed even for a time, but have had to continue working at occupations which have been either physically or mentally laborious—typewriting, for instance, or clerking, or as a factory hand, and so forth. One does not claim that it is more than a palliative remedy, but it is certainly one that may be worth while knowing of and trying in some, if not all, cases of Graves' disease.

The next point that I should like to remind you of is:—

The value of very simple Co-ordinating Exercises in the Treatment of Ataxia,

especially that variety which occurs in tabes dorsalis. Many a patient suffering from this disease becomes bedridden, or at any rate confined to a chair or couch long before he need have been had he been taught to practise simple co-ordination, especially with his legs, in the earlier stages of the malady. This point was first proved by German physicians. It is beginning to be known in England, but knowledge of it is not nearly so widespread as it might well be. A Bristol publishing firm have issued at the price of half a guinea a sort of draught board with circular and diagonal lines and a booklet of directions by means of which the patient can be taught to practice co-ordinating movements with his feet. But there is no need whatever for any complicated diagrams or apparatus. If the underlying principle of the treatment is understood, each of us can devise simple exercises which may be varied week by week or month by month, the patient's interest in them being thereby maintained, though care should be taken to keep them simple and not make them either long or complex. It is important to bear in mind always that the exercises are not required for the purpose of increasing the strength of the individual muscles, for this is already good, as a rule, except in quite a late stage of tabes. The purpose of the exercises should be to call for as little fatiguing effort as possible, but a maximum of precision necessitating the co-ordinated use of opposing groups of muscles. It is easier to demonstrate two or three simple movements than it is to describe them. One of the simplest is to have four or five pennies or small pieces of paper, and to throw them upon the floor at hazard in front of the patient's feet within easy reach, but not too close together. If his ataxy is considerable he may be seated in a chair. If he can manage the movements standing up, so much the better, and if need be he can use a stick or the back of a chair as a support, or he may practice the movements first sitting, then standing. In order to touch each coin in succession accurately with the point of his shoe, or with his big toe if his foot is bare, he will bring into play most of the muscles of his thigh, leg, and foot, and if the movement is continued accurately a marked degree of co-ordination is required. When the patient is already ataxic he will touch each coin clumsily, or may put

his toe down not on the coin at all, but elsewhere on the floor near it. By practice, however, he will re-co-ordinate the movements of the leg and foot muscles until presently his coin-touching efforts will be much more precise and accurate than they were to start with. By varying the position of the coins or by varying the order in which they are touched, sometimes numbering them from left to right, sometimes from right to left, sometimes touching them not in the order 1, 2, 3, 4, but in the order 1, 3, 2, 4, or 1, 4, 3, 2, and so forth, it is possible by means of this simple device and without any costly apparatus to do a great deal towards staving off the time when he will no longer be able to walk. It has been estimated that as much as ten years can be added to some of these patients' lives in this way. It should always be insisted upon that the patient must not go on with the movements at any one time so long as to make his limb fatigued. Their purpose is not to cultivate physical strength, but to teach the muscles once more how to act together to the best advantage. It is a great deal better to practise the co-ordinating movements for two or three minutes at a time half a dozen times a day than it is to have a longer and more fatiguing seance all at one time.

Another very simple exercise which these patients may undertake is for them to stand with their feet sufficiently far apart to prevent their tumbling over, and then to practise rising, not suddenly or quickly, but slowly and steadily from the level foot on to the tips of the toes and then, not to drop suddenly down on the heel again, but to go down slowly and with precision from the tip-toe position until the heel once more touches the floor. At first some of the patients will find this a very difficult movement, and it may be necessary for them to hold on to a chair-back or something of that kind to prevent their falling over in their efforts to rise slowly on to tip-toe, but later the power of co-ordinating the different muscles concerned in the act very often becomes wonderfully restored, even when the first attempts seemed absolutely hopeless.

A third kind of co-ordinating exercise which interests these patients is for them to stand—at first holding on to a chair-back or other support, but later with no support at all—and to raise one foot off the floor and place it with as much precision as possible on a marked spot on the seat of a chair, and then after a pause to raise it from the seat of the chair and to replace it, not with a sudden drop, but with a steady downward movement on to the floor. Each such exercise may be repeated with each foot in turn, and there is a certain amount of co-ordinating effort demanded of the passive leg and foot each time as well as of the one that is being raised on to the chair. If the patient is already so ataxic that he cannot raise the foot so high as on to an ordinary chair-seat, something less high may be used instead —a footstool or a box, for example.

It is clearly easy to devise a great variety of other different movements of a similar kind all having the same purpose, namely, the re-education of the power of co-ordination in the legs, and the trouble taken in this direction in cases of tabes dorsalis, disseminated sclerosis, ataxic paraplegia, and other affections associated with ataxy is well worth while, and well repaid by the improvement in the patient's power of standing and of walking in many cases.

(To be continued.)

Nursing News.

MATRON'S OFFICE.

On November 1st, 1912, Probationer G. Jones was appointed Head Nurse in Victoria Ward.

On November 11th, 1912, Nurse K. Dickson was appointed Head Nurse in Lazarus Ward.

On November 12th, 1912, Nurse Illingworth left the Hospital on completion of her year as Staff Nurse in the Isolation Wards, and Nurse Strange, who completed her three years' training in September last, was appointed to succeed her.

On November 28th, 1912, Nurse Weighill left the Hospital on completion of her three years' training to take up her duties as Sister at the Royal Hospital for Sick Children, Edinburgh, and Nurse A. Hawkins, Head Nurse in Victoria Ward, succeeded her as Head Nurse in Naaman Ward.

On December 2nd, 1912, Nurse Brereton left the Hospital on completion of her three years' training, and Probationer Sullivan succeeded her as Head Nurse in Bright Ward.

On December 6th, 1912, Nurse Patterson left the Hospital on completion of her three years' training, and Probationer M. Simpson succeeded her as Head Nurse in the Out-Patient Department.

On December 7th, 1912, Nurse M. Millar left the Hospital on completion of her three years' training, and Probationer Gilkes succeeded her as Head Nurse in Bright Ward.

On December 10th, 1912, Nurse Colston left the Hospital on completion of her three years' training, and has taken up her duties as Staff Nurse at the Schiff Home of Recovery, Cobham. Probationer Malkin has been appointed to succeed her as Head Nurse in Stephen Ward.

On December 11th, 1912, Nurse Windley left the Hospital on completion of her three years' training. Nurse Gwilliam was transferred from the Theatres to Bright Ward, and Probationer Mott was appointed Head Nurse in the Theatres.

On January 2nd, 1913, Probationer Maher was appointed Head Nurse in Miriam Ward, and Probationer Purves, Head Nurse in Lydia Ward.

On January 4th, 1913, Nurse A. Prince, who since July last has been acting as Staff Nurse in the Massage Department, left the Hospital to take up her duties on the Private Nurses' Staff, and Probationer Angove was appointed Head Nurse in the Massage Department.

On January 6th, 1913, Nurse de Carteret left the Hospital on completion of her three years' training, and Probationer Finlow succeeded her as Head Nurse in Cornelius Ward.

On January 8th, 1913, Nurse Garnett left the Hospital on completion of her three years' training, and will shortly take up her duties as Sister at the County Hospital, Hertford. Probationer F. L. Brown was appointed to succeed her as Head Nurse in Addison.

The following Nurses were successful in passing the examination of the Incorporated Society of Trained Masseuses in November last:—

Nurse Illingworth; Probationers Angove, Ames, Blyth, E. M. Fletcher, M. Hope, Malkin, E. V. Smith, Sullivan, and L. Wood.

The following Probationers were successful in passing the Probationers' Examination in Medicine held in December last:—

First Class.—Probationers Allan, Apfel, Brennand, C. Dean, A. E. Dean, Dodds, Frank, Gladstone, Hayne, Hayter, Holmes, King, Koester, Legge, Looker, Martyn, A. Middleton, Morris, Rae, Raven, Rogerson, Rollo, Rowan, Ryan, Sadleir, Spence, Steward, Tyler-Cove, E. Wallis, Walford, M. B. West, and Wolfe.

Second Class.—Probationers Adams, Archer, M. Baker, E. C. Baker, Barton, Bell, L. Bevan, Cooper, Cox, E. A. Davies, Dearle, Farah, Farr, French, Fryer, Gallagher, Gilchrist, Goudge, Gower, Harding, Harrison, M. B. Haynes, E. M. Humphries, H. Humphreys, M. L. Humphreys, Hyde, M. A. Jones, E. Johnson, E. M. S. Johnston, Knight-Law, Lauterberg, Lithgow, Macrone, Mackie, May, K. Mackenzie, McKitrick, Moss, Murray, Northey, M. Pilkington, M. Potter, Richardson, Sharwood, Staines, Strutt, A. M. Taylor, C. A. Taylor, Tutty, von Pein, Woollett, and Woulfe Brenan.

We much regret to record the death of Miss Millicent Cawley on Sunday evening, the 11th inst. Miss Cawley, who had been visiting friends at Byfleet, was suddenly taken ill, and removed to Miss Manning's Nursing Home at Weybridge, where it was found necessary to perform an immediate operation which, however, proved of no avail.

Miss Cawley entered Guy's as a Probationer in February, 1905, and completed her training in July, 1908, having been Head Nurse in the Out-Patient Department the Isolation Wards, and the Massage Department, and was very popular both with her fellow-workers and patients. In 1911 she took up work as a Masseuse in Brighton and was very successful in that branch of work.

Guy's Hospital Christian Union.

THE next meeting of this Society will be held at 5 p.m. on Thursday, January 30th, in the Chaplain's Room, by kind permission of the chaplains. The speaker will be the Rev. Canon R. C. Joynt, M.A. The meeting will be preceded by tea at 4.30.

O. ST. L. CAMPION,
Secretary.

Appointments.

Royal Navy

Fleet-Surgeon W. J. Bearblock, R.N., has been appointed to *Bellerophon*.

Staff-Surgeon A. W. Iredell, R.N., has been appointed to Chatham Dockyard.

R.A.M.C.

Major R. Tilbury Brown, D.A.D. Medical Services, Sanitary Branch, has been placed under orders for transfer from Maymyo, Burma, to the Eighth (Lucknow) Division Southern Army in India.

Captain G. B. F. Churchill, on return from service in Burma, has been appointed for duty in the Southern Command.

Captain S. L. Pallant has been appointed to Wedgnock Park Camp on transfer from Royal Victoria Hospital, Netley.

I.M.S.

Captain H. C. Keates, M.D., officiating Civil Surgeon at Dera Ghazi Khan, has been transferred to Campbellpur, Attock District, for duty.

Territorial Force.

4th Southern General Hospital (R.A.M.C.).—Gerald C. F. Robinson to be Captain, whose services are available on mobilization (3rd December, 1912).

Civil.

Thomas Holmes, M.D., M.S. Lond., has been appointed Honorary Surgeon to the Cheltenham General Hospital.

C. D. Killpack, M.R.C.S., L.R.C.P., has been appointed Assistant Medical Officer, Workhouse and Infirmary, Parish of Hammersmith.

P. J. Monaghan, M.B., B.S., M.R.C.S., L.R.C.P., has been appointed Assistant Medical Officer, Workhouse and Infirmary, Parish of Hammersmith.

Reviews, etc.

Books for review should be addressed to The Editor, Gazette Office, Guy's Hospital, S.E. Their price should in every case be stated.

Surgery for Dental Students. (Underwood.) Price 3s. 6d. net.

We can confidently recommend this book to all Dental Students. In future there will be no need for the student to wade through one or other of the larger text-books on General Surgery in order to pick our just those parts which he may require. In this little book there will be found set forth most clearly that part of surgery required for examination purposes.

The Elements of Practical Medicine. By A. H. Carter, M.D. Tenth edition. (H. K. Lewis, London.) Price 9s. net.

We congratulate the author on the popularity which justifies the tenth edition of his well-known work.

The text has been brought up to date; much of the old matter has been modified, and many new facts added to what has for years been one of the foremost handbooks of practical medicine.

The author has confined himself to the essentials of disease, and the facts are so disposed as to give the student an intelligent and comprehensive grasp of the principles of medicine, the more important points being further emphasized by underlining and italics.

This manual can be heartily recommended, not only to the men "up for the final," but also to the junior men and the nursing staff as a valuable and eminently readable introduction to the study of medicine.

Pye's *Surgical Handicraft.* Sixth edition. By W. H. Clayton-Greene, F.R.C.S. (John Wright & Co., Bristol.) Price 12s. 6d. net.

The sixth edition of this popular manual fully maintains its former high level in teaching the manipulations of surgery.

The major portion of this handsomely-equipped volume is devoted to the demonstration of such important matters as Treatment of Fractures, Catheterization and minor surgery; whilst, in addition, we find extremely useful chapters on Post-Operative Treatment, Massage, and kindred subjects not usually found in text-books of general surgery.

Another noteworthy feature of this edition is a chapter dealing in an elementary but comprehensive manner with Skiagraphy and its correct interpretation.

The abundance of illustrations, including X-ray photographs, adds to the value of the book, as it enables the student to become familiar with the appearance and usages of the various mechanical appliances.

A work of this kind should prove of great help to dressers, house-surgeons, and private practitioners in the acquisition of that manual skill which is the *sine qua non* of successful practice.

Hockey.

GUY'S v. FOREST HILL.

Played at Forest Hill, Saturday, January 4th. Guy's had a full team out in spite of the holidays, but it was not our full first team. H. C. Rook and L. Bromley very kindly turned out. Forest Hill turned up one short.

It was not a very good game nor played as cleanly as it might have been. However, it was practice and ended very successfully for us as we won 6—0.

Graham was in good form at goal-scoring, and Bromley also got one or two. Rook sent in some good centres, and played well considering it is some years since he last played. Jackson was the best half on the field, and Smith played well. Gripper and Burnside played a good game at back, the latter clearing very cleverly on occasions; Coxon had very little to do in goal and was quite safe. Team:—

GUY'S.—A. C. M. Coxon (goal); G. D. Gripper and B. Burnside (backs); C. R. Smith, R. W. P. Jackson and Minge (halves); H. C. Rook, L. A. Graham, L. Bromley, J. H. Parry, and H. L. Peregrine (forwards).

GUY'S v. EPSOM & EWELL.

Played at Epsom on Saturday, January 11th. Guy's turned up one short, but our opponents kindly lent us an extra man. Bromley again turned out at centre; Purdom was still crocked so played in goal. Team;—

GUY'S.—H. M. Purdom (goal); G. D. Gripper and A. N. Other (backs); C. R. Smith, R. W. P. Jackson and L. Waghorn (halves); C. Vincent-Brown, J. H. Parry, L. Bromley, L. A. Graham, and E. Martin (forwards).

For most of the first half the game was very even with Guy's a little superior. Purdom only had two easy shots to save, whereas the other end Graham scored well from a corner hit, and Parry should have scored from a good pass by Bromley. Half-time came with the score 1—0 in our favour.

During the second half Guy's pressed nearly all the time. Shots by Bromley and Graham were well saved, and others went outside. We could do anything but score. Then during the last ten minutes Purdom foolishly came out of goal and Epsom rushed through two goals which a goal keeper could have saved with ease. Thus Guy's lost by 2—1, which was very disappointing as we had been pressing for about two-thirds of the game. The ground was a mud-lake after the first ten minutes' play, and so anything like accurate passing was very difficult. Bromley and Graham worked hard at forward, but had no luck. Jackson was again very good at half. It would be a good thing if the other men could follow Jackson's example and get in a bit of training before the Inter-Hospital Tournaments.

Births.

ARCHER.—The wife of Herbert Archer, 13, Henleaze Gardens, Bristol, January 7th, 1913, of a daughter.

FRENCH.—On Tuesday, January 7th, 1913, at 62, Wimpole Street, Cavendish Square, to Dr. and Mrs. Herbert French, a son.

SHIPWAY.—On December 23rd, 1912, at 24a, Portland Place, the wife of Francis E. Shipway, M.A., M.D. Cantab., of a daughter.

STURDY.—On Thursday, December 26th, 1912, at 81, Bolingbroke Grove, Wandsworth Common, S.W., the wife of H. Carlile Sturdy, M.D., of a son.

Death.

NORTON-TAYLOR.—On December 27th, 1912, suddenly, at Leyland House, Bromley, Kent, the residence of his son-in-law, Arthur Norton-Taylor, M.R.C.S., L.R.C.P.

Ed.—F. G. S.

GUY'S HOSPITAL GAZETTE.

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Passim.

WE extend our hearty congratulations to the successful candidates at the recent Examinations. Their number is no small tribute to the high level of the tuition maintained at Guy's.

THE need for reform in the case of rheumatic children forms the subject of an interesting lecture by Dr. Poynton, reported in the current number of *The Hospital*. Rheumatism, he considers, is almost as great a scourge as tuberculosis, and yet far too little care is at present exercised in its prevention. We can remember a physician of this Hospital at the end of his rounds one day noticing the fact that of the twenty-four beds he had just visited no less than eleven were occupied by patients in various stages of rheumatic heart-disease. The proportion was, of course, extraordinary and largely a matter of chance, but he pointed out that in a well-to-do practice such a percentage would be impossible. "There is no disease—not even excepting tuberculosis—in whose ætiology poverty plays a more important part." Unfortunately, as Dr. Poynton points out, we cannot make the poor rich, and the English climate is not our personal responsibility; but it is not impossible to teach the parents—especially if there is a tendency to rheumatism in the family—to be on the look-out. The vague "growing-pains" of childhood; a sore throat with pains in the limbs; increasing breathlessness in exertion should be the danger signals.

This is not new knowledge to the ward-clerk proud in the first possession of a stethoscope, yet the signals might pass unheeded by the well-to-do and unnoticed by the Borough mother. Dr. Poynton does not tell how the warning is to reach the latter; nothing short of simple lectures with "tea afterwards" would, we fear, prove sufficiently enticing.

In regard to the important question of the convalescence of rheumatic hearts, it is distressing that there should be so few homes suitable for these cases. In the great hospitals the needs of the more acutely ill rightly claim the precedence, and the student must have a variety of cases suitable for his instruction. Dr. Poynton suggests that Homes should be established in dry and healthy neighbourhoods for the exclusive benefit of rheumatic patients—in which class children suffering from chorea would, of course, be included. As it is, in mild cases of chorea among the lower classes, the injunction that the child shall not go to school merely removes him into a home-life which is almost certainly less healthy, and so any benefit which comes from the mental rest is counterbalanced.

At the present time we can hardly advocate that such Convalescent Homes be set up and kept up at public expense; the strong pay heavily enough for the support of the weak and are beginning to know it. A philanthropist is wanted.

WE should like to congratulate both the Hospital and Dr. P. P. Laidlaw on his appointment to the post of Gordon Lecturer in suc-

cession to Dr. Boycott. Dr. Laidlaw came to Guy's from St. John's College, Cambridge, in 1904, winning the scholarship for Oxford and Cambridge men. His researches on blood-pigments had already made him known as a physiologist, and his career in the wards was exceptionally distinguished. He attained the Cambridge M.B. at the end of 1906, and after holding the posts of Clinical and A.H.S. he left the wards on being appointed Demonstrator in Physiology in September, 1907. In 1909 he left the Hospital, and since then has been working in the Wellcome Research Laboratories. His popularity with his colleagues, and his distinction in research are well recognised among Guy's men. His work has been directed chiefly along physiological lines, but the experience gained in the Wellcome Laboratories is a special qualification for a post in experimental pathology. Dr. Laidlaw will not take up his duties till next October, and in the meantime is going abroad to study Continental methods.

There is a very close connection between Physiology, Pharmacology and Experimental Pathology, but while the first two claim many workers, very much less research is being conducted in the last. We wish Dr. Laidlaw the greatest success in this particular field.

In Germany, experimental work in Pathology is done in research laboratories attached to the clinic. The Pathological Institute confines itself entirely to Morbid Anatomy, and such a separation of two closely allied subjects is widely lamented. We are rejoiced to see that the Hospital has not only appointed Dr. Laidlaw as experimental pathologist, but also Dr. Goodhart as morbid anatomist. By this means both lines of research will be carried out in the same department: and we have no doubt, from the interest of these two pathologists in clinical matters, that their departments will be kept in close touch with the wards.

Four years ago a meeting was held in the Physiological Theatre to inaugurate a section of the Officers' Training Corps among the students of our Hospital. The passage of time and the unavoidable resignation of Captain Davies-Colley affords an opportunity to hold another such meeting. It is to be hoped that all members of the section will attend in the Physiological Theatre on Tuesday next at 4.15 p.m., and will bring those of their friends who are not members, but who are interested in the subject of Volunteer Service. The men just beginning their first or second year particularly should go and learn what service in the Officers' Training Corps means to them and to the country.

The new buildings annexed to the Post-mortem room are now in use as laboratories and lecture rooms. We congratulate the authorities and the works staff on the appointments of the various rooms--and especially on the "epidiascope." This can be used with equal effect for newspaper cuttings and slides. There is now no reason why the most instructive lecture should not be interesting.

We offer our congratulations to Mr. J. P. Jones on being included in the XV. chosen to represent Wales against Scotland on February 1st.

No less than three correspondents have privily written to us that it would be well if a little humour could be sandwiched between the "professional gravity"—the phrase is common to them all—of this journal. "The fool," says one, referring presumably to the professed variety, "is dying out." It is most lamentable. History has it that a delightfully sprightly little periodical published by certain members of this Hospital became a little too fully-flavoured to suit the more delicate digestions and was—discontinued. But it may be that we represent the opposite extreme; and if there be any lampooner of a chaste and delicate wit—and we do not doubt there be many such—let him appear. He will be made very welcome.

The Dental Society's annual dinner is announced to take place this year on February 15th at the Trocadero Restaurant. Tickets, price 7/6, may be obtained from the Secretary, Mr. Guy Neely.

F. G. L. S.
R. O. H. J.

Historical Notes of Guy's.

By FREDERICK TAYLOR, M.D.

III. A Lecturer on Natural Philosophy.

I have in my possession a small book entitled "The Earth, its physical Condition and most remarkable Phenomena, by W. M. Higgins, Fellow of the Geological Society and Lecturer on Natural Philosophy at Guy's Hospital. A new edition, 1855." It is a book of a somewhat popular type, illustrated with many woodcuts.

Who was Mr. Higgins, and when did he lecture at Guy's Hospital? There is no mention of him in the History of Guy's Hospital by Wilks and Bettany, and efforts to find anything about William Mullinger Higgins (for that was his full name), when he was born, when he died, and where he lived, have not been very successful. His scientific output was varied, but not voluminous. He appears to have been on the books of the Geological Society from 1830 to 1835, during which time he published papers on scientific subjects; for instance, one on "Volcanoes," and another on the "Formation of the Dead Sea, and its neighbourhood." His published books number at least eleven, range in date from 1829 to 1873 and embrace the subjects of geology, mineralogy, light, sound, and electricity. They are generally of small size, show a good deal of reading, but little, if any, original research. "The Earth" was published first in 1836, and must have supplied a want, as an edition was published in New York ten years later, the "new edition" in 1855, and a fifth edition in 1869. Not only in the edition of 1855, but also in the first, of 1836, and in that of 1869, Mr. Higgins is described as Lecturer on Natural Philosophy at Guy's Hospital. And here the difficulties begin; for certainly there has been no such lecturer since 1855, from which date the unbroken series of lecturers on Experimental Philosophy can be found in the appendices to the Guy's Hospital Reports. And further, it is on record that Dr. Golding Bird, the father of our Consulting Surgeon, Mr. C. H. Golding-Bird, was appointed Lecturer on Natural Philosophy in 1836, a post he held for seven years, though in the latter part of this time he described himself as Lecturer on Medical Physics. It is highly improbable that there were two lecturers at the same time on Natural Philosophy, or that Mr. Higgins again took up the subject in general, when Dr. Golding Bird was specialising in its medical aspects. The solution comes when we look at the title-pages of two of Mr. Higgins' earliest works; for in the "Mosaical and Mineral Geologies," published in 1832, he makes no claim to a connection with Guy's Hospital; and he first mentions the appointment in an "Alphabet of Electricity" published in 1834. Thus, he must have lectured from some time in 1832 or later, up to the middle of 1836; and this would have justified his claim to the title in the first edition of "The Earth" in that year. That he is credited with being still attached to Guy's Hospital in 1855 and 1869 is, no doubt, due to carelessness or inadvertence in editing; and in the last work available, namely, that published in 1873, he is described as "formerly Professor of Natural Science at Guy's Hospital," a title which must have been very rarely conferred upon anyone by the authorities of our Medical School!

From the various dates given, it is clear that he could not have been born later than the first decade of the last century, and as centenarians are rare, he has probably long ago passed over to the majority. Peace be to his ashes!

University of London Officers' Training Corps.

Medical Unit. "B" Section.

SECTION NOTICES AND ORDERS.

1. The undermentioned cadets passed certificate "A" and "B" examination, held in November, 1912:—

Certificate "A"—

Cadets W. W. K. Brown.	Cadets T. R. Trounce.
„ H. R. Sheppard.	„ J. Stephenson.

Certificate "B"—

Cadet E. Biddle.

2. The following promotions are made to date December 14th, 1912:—

To be Cadet Lance-Corporals—

Cadet G. P. Kidd.	Cadet G. D. Tripper.

3. The undermentioned cadets having been enrolled, are assigned numbers as under:—

3454. Moore, L. W. (Guy's), 17th December, 1912.

3458. Campion, O. St. L. (Guy's), 18th November, 1912.

4. Cadet M. St. C. Hamilton is transferred to the Section from "F" Company, Infantry, Mint, and alloted No. 3459.

5. A general meeting of the Section will be held in the Physiology Theatre on Tuesday, February 4th, at 4,15 p.m. A scheme of work for the coming year will be outlined, and all students who are interested in the Corps are invited to attend, whether they are thinking of joining or not.

T. B. LAYTON, Lieut. R.A.M.C. (T.)
O.C. "B" Section.

London Bridge and the Borough in the Eighteenth Century.

(*Continued from page 28, new vol.*)

XVI.

THE CLINK AND THE STEWS.

"But shall all our houses of resort in the suburbs be pulled down?"
. . . "To the ground, mistress."
Measure for Measure, act 1, sc. 2.

The mention of Dr. Johnson in our last essay reminds us of his habit of touching with his hand each of the street posts as he passed. This was an obsession with George Borrow also, in whose case the action was prompted by an instinct to avert the malign influence of the "evil eye."

Johnson, during the years of his residence in Park Street, had no lack of opportunity to exercise his foible when taking his walks in the Borough. Then, as now, the footway was guarded at intervals by street posts from the "kennel," or gutter, and the traffic in the road, but it was then an unpaved footpath, and the posts were all the more necessary to mark the distinction between the two regions. Gay, in his "Trivia," an amusing description of London streets in the early eighteenth century, gives advice that may still be followed at the present day.

"Where porters hogsheads roll from carts aslope,
Or brewers down steep cellars stretch the rope,
Where counted billets are by carmen toss'd,
Stay thy rash step, and walk without the post."

So much to introduce to your notice the only one of the many dummy cannon in the Borough High Street which bears an inscription. It is placed at the northern side of the entrance to King's Head Yard, and is inscribed, "Clink, 1812." This and an almost illegible notice board near St. Saviour's Dock constitute the visible testimony, now remaining, to the once famous "Liberty of the Clink."

From early times the manor attached to Winchester Palace, under the jurisdiction of the bishops, had been known as the Liberty of the Clink. Not that its inhabitants enjoyed any special "liberty" in the modern sense; far less, indeed, than did their neighbours within the close of the priory of St. Mary Overy's, which degenerated, after the suppression of the monasteries, into the lawless "Alsatia" of Montague Close. On the contrary, the bishops maintained strict rule within their dominion; the Clink prison, at the corner of Gravel Lane and Maid Lane (now Sumner Street) was ever ready to receive "such as would brabble, frey, or break the Peace on the said Bank," and through his steward or bailiff, the bishop held not only a court-leet, but "a Court of Record on the Bankside for the pleas of debt, trespasses, &c." The manor had an area of about 70 acres, mostly included in the park attached to Winchester House. The Liberty extended north to the Thames, west to Christchurch or Paris Gardens (Blackfriars Bridge Road), east to St. Saviour's Dock, and south to the boundary of St. George's parish.

Strype's 1722 edition of Stowe gives us the boundaries in detail: "Part of Church way, *Dirty Lane* (Bedale Street), Rochester Yard, Winchester Street, Primerose Alley, St. Saviour's Dockhead, Winchester Yard, Clinke Street and Yard, part of *Deadman's Place* (Park Street), *Globe Alley, Naked-Boy Alley, Vine Street, Maid Lane, Marshal Street, Fountain Alley*, Horseshoe Alley, Rose Alley, Bear Garden, *New Thames Street*, Morse's Alley, White-hind Alley, *Barton Court, Gardener's Lane, Back Side, Willy Street*, Red Cross Street, Alley, and Court, *Angel Court*, Castle Street and Lane, part of *Fishmonger's Alley, Queen Street* (Union Street), Worcester Street, Whitecross Street, *Little* and *Great Bandy-leg Walk* (Guildford Street), *Lower Street*, Ewer Street, *Duke Street, Prince's Street, Lowman's Pond* (Loman Street), Orange Street, and Pepper Street."

At the Dissolution neither the Palace nor the Liberty was sequestrated from the bishops of Winchester, who continued to keep watch over the moral and spiritual welfare of their parishioners. The old prison at the end of Maid Lane fell into decay about 1745, and was abandoned, the prisoners henceforward being lodged in a dwelling-house on Bankside appropriated in its stead. The Gordon rioters in 1780, having been induced to spare the brewery, turned their attention to the Clink prison, and burnt it to the ground, and "no other prison has since been established for the locality."

St. Saviour's Dock formerly extended much farther inland. In 1791 the authorities at length realised that it was "filthy, smelled very badly, and annoyed the people," and in consequence ordered that a great part of it, some 110 feet of its length, was to be filled up. Opposite its present landward extremity, above the planks which close the end of a dingy little lane, is a board on which may still be traced the announcement that Primrose Alley was "closed by order of the Clink Commissioners, 30th March, 1854." In 1877 the bishop claimed the exclusive use of the landing place, but his claim was stoutly resisted by the inhabitants, and on their behalf a notice board asserting the public right to use the dock was set up against the wall for all to see, and there it remains to-day. In the same year the diocese was transferred to Rochester, and since that time little more is heard of the Liberty of the Clink.

Within the sphere of influence of the bishops, and under their control, were the "Stew-houses," public lupanars which existed before the time of Henry II. Previously regulated by custom alone, in 1162 they were at length legally recognised by Parliament, and rules for their conduct were drawn up. The patents then granted were confirmed in 1345, and at subsequent dates.

At the time of the rebellion under Wat Tyler, Jack Straw, and John Ball in 1381, "these stew-houses belonging to William Walworth, then Mayor of London, were farmed by Froes (D. *vrouw*, G. *frau*), of Flanders"; and we can read in Froissart how the rebels "went from street to street and slew all the Flemings that they could find in church or in any other place; there was none respited from death." The mistresses of the stew-houses suffered like their worthier compatriots, for the rebels attacked the houses and pillaged them. In their fury against foreigners the mob also "brake up divers houses of the Lombards and robbed them and took their goods

at their pleasure, for there was none durst say them nay." Among the victims in South London were the colony from whom *our* Lombard Street (off the Marshalsea Road) derives its name. It is recorded that the unhappy Italians failed to pronounce the words "bread and cheese," a shibboleth imposed as a test of nationality.

The rebellion collapsed with the death of Wat Tyler at the hands of the Lord Mayor and his followers. Some of the old historians have been uncharitable enough to add that Walworth's action was prompted by resentment at the destruction of his property on Bankside. The Fishmongers' Company, of which Sir William Walworth was a member, still preserve in their Hall across the bridge a sword alleged to be that with which the rebel leader was slain. Tradition has insisted again and again "that the 'dagger' in the City arms was granted at this period in commemoration of Walworth, the Mayor, having given Tyler the blow with that instrument which was the prelude to his death." Nevertheless, it has been clearly proved that the short sword was established *in dexter chief* on the City shield long before that time, and represents the weapon of the City's patron, Saint Paul.

Of all the bishops of Winchester, the name most frequently associated with the establishments on the Bank is that of Cardinal Beaufort; possibly because one of the houses bore the sign of "The Cardinal's Hat," but mainly from the allusions to this prelate in Shakespeare's "King Henry VI." In that play, among *Gloster's* many ourbursts against the Cardinal, reference is made to his granting "indulgences to sin," and the epithet "Winchester goose" is applied to him. The latter appears to have been a common nick-name for the inmates of the stews, which was still remembered in the early seventeenth century by Taylor, the water-poet, in a brilliantly-rhymed couplet,

"Then there's a goose that's lived in Winchester,
And of all geese my mind is least to her!"

The rules and regulations for the management of the houses, still preserved in the Bodleian, were drawn up in 1430.

In 1506, says Stowe, quoting Robert Fabian, "the said stew-houses were for a season inhibited, and the doors closed up, but it was not long ere the houses there were set open again, so many as were permitted, for (as it was said) whereas before were eighteen houses, from thenceforth were appointed to be used but twelve only." Again, in 1535, they were ordered "to be *as far as possible* publicly and entirely suppressed"; and finally, in 1546, "this row of stews was put down by the King's commandment, which was proclaimed by sound of trumpet," and the inhabitants were commanded to "keep good and honest rule as in other places of this realm."

This suppression was not acquiesced in without protest. So good a man as Bishop Latimer, in a sermon preached at Edward VI. (poor child!), strongly averred in the franker language of Tudor days, that the effect of extirpating this primary focus had been to disseminate the mischief over the rest of London. In Queen Mary's reign some attempt at reviving the stews was made, but not persisted in.

Van den Wyngaerde's map of 1543 clearly shows the range of houses lying west of the two episcopal palaces, but rather further from the riverside. As time goes by, the houses cease to be marked expressly on the later maps, but, as we hope to show, their memory was perpetuated in other ways.

According to Stowe's description, "These allowed stew-houses had signs on their fronts, towards the Thames, not hanged out, but painted on the walls, as a Boar's Head, the Cross Keys, the Gun, the Castle, the Crane, the Cardinal's Hat, the Bell, Swan, &c." The recurrence of certain of these signs as place names, sometimes through the intermediation of the device borne by a tavern seems to justify the inference that some of the establishments, diverted in some degree from their original purpose, were afterwards carried on, ostensibly at least, as public-houses. A locality shown in Rocque's map conveys a broad hint that the old traffic was still carried on, even though divested of the episcopal patronage.

The argument must not be pressed incautiously, however. The historic "Boar's Head," already mentioned in the essay on the Borough Inns, can obviously owe nothing to the "house of resort" on the Bank; but another inn of the same name that existed in the seventeenth and eighteenth centuries on the western side of Counter Street might claim the inheritance with more probability in point of time and place. Again, the sign of the "Crossed Keys" once hung in the Borough High Street in pre-Reformation times; but the keys of St. Peter, borne *saltire-wise*, were too evident a reminder of former papal control, and so, in the reign of Elizabeth, the inn adopted the more patriotic sign of the "Queen's Head." This in earlier times had been the mansion of the Poynings, one of whom was sword-bearer to Jack Cade. In 1637 the inn was the property of John Harvard, the founder of the American university that bears his name, who is commemorated in St. Saviour's.

Swan Street, beyond St. George's Church, was named after a brew-house.

On the other hand, Bell Yard once stood where Southwark Street now joins the High Street.

Still more probable is it that Castle Street owes its name ultimately to the "allowed stew-house"; there was a tavern of the same name in Holland Street in the intervening centuries. Both Castle and Cardinal's Cap are mentioned in the accounts of Sir John Howard, first Duke of Norfolk; whilst Cardinal's Cap Alley was paying rent to the prior of Merton as early as 1468, and the site, at the western end of Bankside, and the name of the alley were still shown on the ordnance maps of the district as recently as 1877.

Curiously enough, however, we must to-day cross the river for the most direct reminiscence of these houses. Stew Lane, in Thames Street, still leads to a riverside stairway in Queenhithe between Brook's and Maidstone wharves. Stew Lane Stairs are due north of the ancient site on the Bank and are said to have been the only stairs by which the inmates of the stews were permitted to land in the City. To mark their forfeiture of civil rights, these miserable women were subjected to many indignities, and even when overtaken by death, if they had not previously renounced their manner of living, the bishops, to mark the abhorrence with which they regarded the calling, refused them Christian burial. "And therefore there was a plot of ground called the Single Woman's churchyard, appointed for them far from the parish church."

The burial ground was situated behind the Greyhound Yard in the Borough, afterwards cut through to Red Cross Street to form Union Street. This appears to have been one of the sites suggested for the new Borough market in the eighteenth century. It came to be known as the Cross-bones burial ground, and here in 1791 was built the St. Saviour's Charity School where the "red-cap boys and the blue-cap boys to the number of 70" were educated. The graveyard was much overcrowded, and at length was closed to burials by Order in Council, 1853. The ground passed out of the hands of the ecclesiastical authorities, but building operations were not permitted, and after many years as the site for fairs, roundabouts, and cheap shows, was at length cemented over and enclosed as a factory yard.

The very modern ring of the following verse—

"Blessed Saynt Saviour
For his naughty behaviour
That dwelt not far from the Stewes
For causing infidelitie
Hath lost his dignitie,
Of him we shall have more news."

would scarcely lead one to suspect that it first appeared in "A Book entitled The Fantassie of Idolatrie," published about 1540.

(*To be continued.*)

Guy's Hospital Dental Society.

A MEETING of the above Society was held on January 9th, at 4.15, Mr. Ernest B. Dowsett in the chair.

The minutes of the previous meeting were read, and, after correction, confirmed.

Mr. C. H. Edwards showed an interesting casual communication of a supranumerary tooth in the bicuspid region.

Mr. C. F. Haine then proceeded to read his paper on Local Anæsthetics, which was of an exceedingly interesting character. The paper, which gave proof of much thought and energy having been spent upon it, was to some extent marred by the sleepy manner in which it was delivered. We suspect that the writer wished, after the manner of G. B. Shaw, to intensify the brilliance of his remarks by his grave and indifferent manner.

The discussion which ensued was marked by the eagerness of men to get on their feet, not once, but even twice and three times, a distinctly encouraging and pleasing feature.

Mr. Lancelot T. Montgomery, for instance, treated his audience to three separate speeches, all of which for Irish humour and improbability were unequalled during the whole of the discussion.

Mr. Stradling, we are led to believe, considers public-speaking good practice for examination vivas, for he delights in asking questions of a perplexing nature. In two speeches, delivered in the inimitable Stradlian way, he was most effective, and his manner of saying, "Sir, I would like to ask," is really impressive.

Mr. Bulleid spoke but once. We like the way in which he habitually thanks the writer for his most valuable paper. We imagine that he prepares his speeches, for they are generally good, if a little too technical.

Mr. Underwood, in a quiet way, has an unfortunate knack of making previous speakers feel uncomfortable. We ourselves came in for our full share of righteous condemnation. We gather that his view of asepsis is to give both the patient and the operator a Turkish bath at a temperature short of actual boiling point before the administration of a local anæsthetic.

Mr. Price-Harris is suave and fluent. He received quite an ovation on rising. It must have leaked out that he was to have read a paper at this meeting, but has now definitely abandoned all thought of such a thing. We should like to hear his right-hand man, Mr. Fry, from whom he gathers a great deal of his knowledge, speak occasionally.

Mr. Saul tells us that he can only be really eloquent on New Year's eve. We cannot think why, but his speech on this occasion rivalled the masterpieces of Demosthenes.

Mr. Thomas, for some unknown reason, did not speak, but Mr. Edwards sportingly filled in the gap with a somewhat sheepish speech.

The president, in a very excellent speech, wound up the discussion, enriching the debate with many choice remarks.

The House noted with deep gratification the presence of a distinguished military-looking gentleman. All three H.S.'s were present; surely a mistake! If this last remark appears somewhat inaccurate, we would venture to suggest that the other Dental correspondent, or some equally intelligent person, report the proceedings of the next meeting, when Mr. Charles will read his paper on the Macroscopic Anatomy of the Human Promolar Teeth. We are always glad to see Mr. Doubleday.

We would like to remind men that the Annual Dinner takes place on Saturday, February the 15th, and trust that they will buy tickets with as little assumed reluctance and with as few complimentary epithets about the secretary as possible.

Pupils' Physical Society.

A CLINICAL MEETING of the above Society was held in the Wills' Library on Saturday, January 18th. Mr. G. S. Miller was in the chair, and 20 members were present.

The following cases were shown: Stokes Adams Syndrome, by Mr. James; Obscure Pigmentation, by Mr. James; Purpura, by Mr. Seabrooke; Acute Adiposity, by Mr. Harrison; Tuberculous Testicle, by Mr Minns; Toxic Optic Neuritis, by Mr. Rook.

The following members took part in the subsequent discussion:—The President, Dr. H. C. Mann; Messrs. Robinson, James, Seabrooke, Pedley, Edmond, Richards, Heaton, Fawcus, and the junior Hon. Sec.

Gazette Special Pathologist.

H. V. M., CLACTON-ON-SEA.—This sputum is comparatively non-purulent in character, and tubercle bacilli are not detected. PATHOLOGIST.

The Diagnosis of Suppuration in the Accessory Sinuses of the Nose.

CLINICAL LECTURE BY T. B. LAYTON, M.S.

GENTLEMEN,—I intend to-day to illustrate the diagnosis of inflammation of the sinuses of the nose by cases that have been under my care during the time I have had charge of the Throat Department. If a patient come to you suffering with a purulent discharge, the cause of this is either a suppurative inflammation of the mucous membrane or a suppuration in one or more of the sinuses which open into the nasal fossa. In order to say which condition is the cause you must carefully wipe away the pus from all parts, and then look again after ten minutes or half an hour to see if it has returned. With an exception which I shall mention later, when the pus returns within half an hour you may be confident that it is overflowing from some sinus and has not been secreted in that short time by the mucous membrane of the nose, for the mucous membrane cannot have secreted a definite bead of pus within that short period. If no pus has returned in that time an inflammation of the mucous membrane lining the nasal fossa proper may be the cause.

I would lay stress on the need of waiting a whole half hour when you wish to establish the diagnosis from the negative point. If at the end of ten minutes the bead of pus is again there, your positive diagnosis of sinus disease is made; but if it is not, another wait and another look is necessary to exclude this. That point was brought home to me by the following case:—

Case 1.—A girl had had sinus disease on the right side, for which Mr. Steward had done a radical operation in the frontal sinus. Purulent discharge had now appeared on the left side, and on looking a quarter of an hour after the wiping had been done, the cavity was quite clear. The girl had had a long wait, and was disappointed at not seeing Mr. Steward. As a result she was cross, and looked upon me as an interloper; every tone of her voice and every movement of her head told me that I was entirely out of her confidence, and at this stage she wanted to get up and go away, thankful that she had no sinus disease, and glad to be rid of us. It was, therefore, with some difficulty that I persuaded her to stay; and that subsequently impressed the point upon my mind, because on our second examination in another quarter of an hour there was the bead of pus again in the middle meatus. Had we made up our minds on the first examination we never should have continued our investigation, but should have classed it as a case of rhinitis only.

Indeed, when true pus is present in the nose, I doubt whether it is ever due to a mere rhinitis. The discharge in this last is that of a muco-pus rather than real pus, and, therefore, I would urge on you rather to doubt your examination and repeat it in a few days, than to make a diagnosis of rhinitis only. This point is well shown by the following case which I had intended to bring forward as a case of simple rhinitis when I began to prepare this lecture, but about which time has compelled me to change my opinion.

Case 2.—A married woman, æt. 29, came up in September, and Mr. Bromley, who was then clinical assistant, made a note that he was suspicious of sinus disease. A week later we wiped away the pus and waited as usual, and at the end of half-an-hour none had returned. This I thought to be the first case I had ever seen of a mere rhinitis with purulent discharge. We treated her for the rhinitis, and she said she was much better. In the first week of December the pus seemed so viscid and so definitely to be coming from the front end of the hiatus semilunaris that I determined to repeat the examination. While I was examining another case the dresser came to me and said no pus had returned; he was, however, wrong, for a bead of pus was present at the front end of the meatus, and could only be seen by looking high up under the anterior end of the middle turbinal when the patient had extended her head far back.

To repeat, then, our first stage in the diagnosis is to wipe away the pus and to see if it return. Easy as this may sound there are already one or two pitfalls which may make even this stage doubtful. First, it requires some practice thoroughly to wipe out the nose; you may return to it, and seeing some pus have an uncomfortable feeling that you had omitted that nook or cranny in your preliminary cleaning. Then must you clean it again and wait again. A very little experience will serve to eliminate this fallacy. A more difficult case occurs when there are polypi or a polypoid condition of the mucous membrane; little pockets may be formed between two or three small polypi as they touch one another, and thus give the symptoms of sinus disease, or the polypi may obscure the sinus disease by blocking the outlet of pus from them. When these conditions are present the nose must be well painted with cocaine and adrenalin, the small excrescences of polypoid mucous membrane will then shrivel up, the pockets become opened out, and the process of wiping and waiting can be begun again.

Case 3.—A nervous young girl, æt. 22, came up complaining of difficulty in breathing through the nose. The nose was full of polypi covered by a muco-purulent secretion; we removed the larger of these at two sittings, but beneath were many minute polypoid masses; she was taken into the hospital and the free edges of the middle turbinal processes were removed under an anæsthetic. A day or so later the antrum was explored and found to contain pus. Another case (Case 6) showing the same points, I shall refer to later.

In the case of the parts above the middle turbinal process, anatomical considerations introduce other difficulties. Firstly, the pus may never come down the front of the nose at all, and then it can only be recognised with the posterior nasal mirror.

Case 4.—Dr. Eason brought down to my Out-Patients the other day a woman suffering from a left ophthalmoplegia, which had been under observation for some time. Certain causes of this had been excluded, and he wanted to know whether there were any signs of sinus disease which might account for it. From the front there was no sign of any inflammatory condition in the nose, but with the posterior nasal mirror I could just see a small bead of pus at the top of the left posterior choana. This is a sufficient suggestion of disease of the sphenoidal or posterior ethmoidal cells to make it necessary to follow up the symptom.

Secondly, the middle turbinal is normally so near to the septum that the slightest swelling will make it touch; when this occurs the parts above it become shut off from the rest of the nose, and the pus secreted by a purulent rhinitis becomes pent up and escapes a bead at a time in the same way as it does from a sinus. Therefore, with pus in this part of the nose, the fact that it returns within half an hour does not prove that it is sinus disease. This is the teaching of Prof. Hajek, and he is a man who puts great care into his work, which he does with such exactness that anything he says must be most fully considered before it is discarded, but I have already told you that I am somewhat doubtful of these cases of simple rhinitis, and I must admit that I am somewhat sceptical as to this statement of his.*

When you have concluded that there is sinus disease you must be able to say whether each of the six sinuses or sets of cells opening into the nasal fossa is involved or not. This must be done by a process of exclusion which in a complicated case is a matter of much difficulty and takes some time to decide; the first steps are, however, not very hard, and may be done by anyone with a sufficient knowledge of anatomy.

*Since the lecture was delivered, I have seen a case which will, I believe, prove his teaching to be correct.

First, then, we must consider the anatomical position in the nose from which the pus is coming. If from the middle meatus only, it must be from the maxillary or frontal sinuses or from the two front sets of ethmoidal cells. If it is coming down from between the middle turbinal and septum, it comes from the superior meatus, and therefore from the posterior ethmoidal or sphenoidal sinus. The differential diagnosis of these latter is very hard, and I have not yet had cases enough to illustrate all the points. We will therefore limit the further consideration to a case where the pus comes only from the middle meatus.

So far as we have gone we have learnt that our patient is suffering from sinus disease, and that the disease involves one or more of those opening into the middle meatus. Of these, the largest, the one most easily investigated, and the one most often involved, is the maxillary sinus. It is well, therefore, always to begin with this cavity. The maxillary sinus may be explored from the nose, from a tooth socket, or from the canine fossa.

When there is some suspicion of malignant disease, and it is necessary to see inside the antrum or to remove some mucous membrane from within it for microscopical examination, the last is the route that must be chosen. To-day, however, we are dealing with simple inflammatory diseases, and need not further consider this route, as the operation is a bigger one than either of the others, and would never be used for simple exploratory puncture; nor shall we go into the vexed question whether a maxillary sinus should be drained permanently through a tooth socket, as our subject is the diagnosis only of the disease. We may, however, say this, that whatever the cause of the discharge from the nose, the treatment of any carious teeth is a part of the treatment of the nasal condition, and therefore if there is a tooth through the socket of which the sinus may be explored and which will have to be removed later, it forms a very useful route for clearing up the next stage in our diagnosis. The following case will make this point clear:—

Case 5 is a man who had been under treatment for some time with syphilitic disease of the mucous membrane of the nasal cavity, and on Friday, November 22nd, he came up with a swelling and redness of the cheek over the anterior wall of the sinus extending up to the lower eyelid and on to the side of the nose. This must have been due either to a suppuration of the sinus, which had destroyed the anterior wall, or to an extension of the syphilitic disease to the soft parts in this region. From the soft œdematous nature of the swelling, as distinct from the more indurated firm condition found in

syphilis, we thought that it was the former of these, but to confirm this it was necessary to explore the sinus. The dental house-surgeon, Mr. Bevis, came over and told us that the second premolar was quite a useless tooth which was better out. So we gave him gas. Mr. Bevis removed the tooth and drilled the sinus. As soon as the drill was removed a gush of pus came away, and after he was round from the anæsthetic a lot more was washed out with a syringe.

Here, then, was a case in which exploration by a tooth socket was very valuable for diagnosis. In the majority of cases, however, you will want to explore through the inner wall of the nose, either because you do not want to give gas, or because you have no useless tooth which can be extracted, or because you have no skilled dentist to extract it.

The sinus opens into the middle meatus of the nose at the bend of the hiatus semilunaris. This opening is bounded mesially by the ridge of bone and mucous membrane forming the boundary of the hiatus, and to pass a cannula into the sinus you must go up under the middle turbinal, then down the hiatus, and then out into the sinus. The passage of such a cannula is often impossible and at all times hard. Professor Hajek says he can do it in about one out of four or six noses; but up to the present time I have been unable to do it. Below the hinder end of the hiatus, and just above the inferior turbinal bone, is the thinnest part of the sinus wall; often it is formed only by the two layers of mucous membrane being in contact with one another; when osseous tissue is there it is only of papery thickness, and a negligible factor in the passage of a hollow needle. Here also in a certain proportion—about one in four—is the accessory opening of the sinus, and when that is present a bent cannula will pass into it and the sinus may be washed out from there.

Case 6.—A woman, æt. 32, came up complaining of frontal headache and discharge from the nose. First, many polypi had to be removed. Then we could wash away the pus, and found it return at once, so we knew she had sinus disease. I then tried to wash out the antrum through the accessory opening, but so many small polypoid masses were present that it was hard to say whether the end of the cannula was in an accessory opening or in among various polypoid masses. The sinus was, therefore, explored by the inferior meatus. After two months' treatment the condition was so much better that we confirmed our former suspicion of an accessory opening and were able to wash out the antrum through this without having to apply cocaine and puncture the inferior meatus.

Most frequently the sinus is explored from the inferior meatus. The sinus varies considerably in extent and in the thickness of its walls. The only constant portion is the upper and back parts, and, therefore, to drill it from the inferior meatus you must go high up under the back end of the process. From my own experience, and from that of dressers who have worked under me, I find that the commonest mistake is not to go far enough back when first you do this operation. You must remember that there are the soft parts of the nose and the dense nasal process of the maxilla to be passed before the thin bone beneath the inferior turbinal process is reached, and so the needle must pass in quite two inches, and often three, before the puncture should be made.

Case 7 was a boy, æt. 17, whose antrum I tried to puncture. Under local anæsthesia I made three attempts, and ended up by breaking off the point of the trocar in his nose. He was then taken in and the foreign body removed; then, under the anæsthetic, his antrum was punctured by putting a long, straight, hollow needle high up and far back under his inferior turbinal bone.

When the needle is in position, a little air is first blown through it. This will tell you whether or not your point is beneath the mucous membrane on the other side of the antrum; if it be so, and you inject water beneath it, you will strip up the mucous membrane and expose a large area of bone to the infective processes. By blowing a little air through, a bubbling sound will tell you that the needle is at the right level. This is a small detail always insisted upon by Professor Hajek in his clinic, and that it is a necessary detail has been brought home to me twice during the last few months; on one occasion I felt the end of my needle grate against the bone of the other side of the antrum, and on another, as I blew the air through, I heard no gurgling sound. In each of these cases I withdrew the needle slightly, and, on blowing air through, the characteristic gurgle was heard or rather felt, as it may be appreciable to the operator and not to the bystanders. Professor Hajek says that you may even from the inferior meatus put your needle into the orbit without knowing it; the advantage, then, of blowing up the cellular tissues of the orbit and eyelids with air rather than with water is apparent. I am glad to say that I have not yet done this. It is, however, the reason why the same authority urges that the antrum never should be punctured through the middle meatus; in some persons the upper part of the antrum is so narrow from the floor of the orbit, sloping downwards, that the needle may be into the orbit almost at once. It is impossible, looking at the patient or his nose, to tell

whether he has such an antrum or not, and, therefore, it is well never to puncture through the middle meatus. That this view is not held by everyone is shown by the fact that in the clinic of Prof. Killian,* at Berlin, the antrum is always explored through the middle meatus, and the inferior meatus is only used when an attempt by the former route fails for some reason or another. There are certain advantages of puncturing through the middle meatus; as I have said before, here is the thinnest part of the inner wall of the antrum, and here also is its constant portion, but I prefer the inferior meatus myself, because the needle is easier to manipulate, and because of Prof. Hajek's warning. Whatever means of puncture be employed, on washing out the antrum the presence or absence of pus in the washings will tell whether this sinus is involved or not.

Just before syringing through, remember to see that the nasal fossa is empty of pus, or this will come away with the washing, and lead you to think that the antrum is involved when the pus may originally have come from the frontal sinus or ethmoid cells.

When the condition of the antrum has been determined the middle meatus of the nose must again be wiped clean, and after another wait again examined for pus. If this still return within half an hour we may argue that another sinus is involved, for the antrum cannot have secreted so much pus in that time that its cavity has become filled and it can flow over into the meatus. This was well shown in the first case I mentioned to you. We explored the left antrum, in the washings was pus; and it was in the wait for the further return of pus that I had the difficulty in persuading her to stay. Had no pus returned in her case our diagnosis would have been complete. We could have said, "This patient is suffering from suppuration of the maxillary sinus, and of no other sinus"; but as, at the end of half an hour, there was again a bead of pus, all we could say was, "This patient is suffering from suppuration in the maxillary sinus and also in the frontal sinus or the anterior or middle ethmoidal cell, or in all three of these."

The further examination of Case 2 exemplified this point still better. For, on the right side, after puncture and washing, no pus returned, while on the left it quickly returned, even after the maxillary sinus had been washed out.

*Killian's median rhinoscopy is another method. The nose is painted with cocaine and the middle turbinal pushed aside with a specially made speculum.

The next stage is to differentiate between these three. We proceed with the frontal sinus in the same way as we did with the maxillary one, by washing it out after the nose has been cleaned and seeing if there be any pus in the washings. If there is none, the ethmoidal sinuses are at fault only; if there be pus in the washings from the frontal sinus then this sinus is involved, and once again must we wipe the meatus clean, once again must we wait the half hour to see if the ethmoidal cells also are involved. This passage of a frontal sinus cannula is no easy matter, even when the way is clear it requires some practice to pass it, but often the way is not clear, and we must consider what may be the cause of obstruction. Firstly, the swollen mucous membrane alone may be enough to stop the passage, the application of adrenalin and cocaine will then shrivel it up and allow both the escape of pus and the passage of the cannula. Sometimes, however, the middle turbinal is so incurved that its anterior end must be removed in order to pass the cannula. Professor Hajek describes "a high removal" of the middle turbinal for this purpose, by which he means that it must be cut away from its attachment to the lateral wall of the nasal fossa, and not merely its free margin snipped off. Again, I told you above that the middle turbinal lies very close to the septum, and a slight deviation of this with the convexity to the diseased side may so press on the turbinal that it cannot be removed. In such a case Hajek advises that the deviated septum be operated on. I did this in Case 6, to which I have already referred. Finding I could not remove the middle turbinal, I removed a small piece of the septum which was pressing on it. This operation I did from the concave side, and no bad effects resulted from doing in the presence of the pus on the convex side. I was then able to remove the front end of the middle turbinal and so wash out the frontal sinus

By such means the frontal sinus is excluded or included in a way similar to the maxillary sinus. If, after washing out the frontal sinus, pus continues to return, then are the ethmoidal cells involved. You cannot differentiate between the anterior and middle set of the labyrinth, nor is this necessary for the purpose of treatment.

I would impress upon you three lessons from what I have told you. First, that the exact diagnosis of these things is a matter of considerable time; it cannot be made in a day and

often not in a month. Some of you may think that valuable time is being wasted from the slowness of the diagnosis; this is not so. The disease which we are discussing is a chronic one; it has possibly been existing for years, and it is impossible to cure it in a few days. The very methods which you use for diagnosis are those which you use for treatment. This is well seen in Case 6, to which I have already referred three times. She has been under my care for four months, and I know she has an inflammation of her maxillary sinus and of her ethmoidal cells. Whether her frontal sinus is involved or not I am not quite sure, but of two things I am very sure—that she is much better, and that even if the frontal sinus is involved I have secured an efficient drainage, and am not going to do anything further for it. In her case this area of the middle meatus is only just free of minute polypoid masses, and at the next examination or the one after I shall be able to convince myself as to the condition of the frontal sinus; so far, I have not found any pus on washing out this cavity, but I try to retain a healthy scepticism of any negative examination and I only say at present that I think this sinus is not involved.

My second lesson is that this diagnosis is not easy. To wipe, to look, to puncture, to wash out, to wipe again, and look again; it sounds so easy, it is so hard. That is the reason why rhinologists are always talking of it. I have told you of many pitfalls which I have encountered. I dare say there are yet in store for me many more. I think it is unlikely that many of you will become rhinologists—a larger area of the body will furnish you with your life's work. Why, then, do I go into such detail on the subject? Because you must have sufficient knowledge of the subject to be able to form a critical opinion of the specialist, and because when practising general medicine you must know your limitations in the special subjects. And this answer suggests another question. How far should you be prepared to take such a case yourselves? If I may do so, I suggest that you go so far as drilling the antrum and cleaning the nose after. If this cavity only is involved, well and good, if there is evidence of disease in others also I advise you to pass on the case to one who has more time to devote to the nose than you have.

Thirdly, remember that the method of exclusion which I have described is the only way of making a diagnosis; short of this a guess may be made, but the only safe thing to work upon is an exact diagnosis under the three heads:—

a. Is there any sinus disease?

b. Which sinus is involved?

c. Is each of the other sinuses free from suppuration?

Genito-Urinary Tuberculosis.

The following statement is a brief summary of the cases of genito-urinary tuberculosis which have been recorded in the post-mortem reports of Guy's Hospital between the years 1890 and 1909, inclusive, and the reports of the Victoria Hospital for Children since 1889 up to the end of 1912. The total number of post-mortem reports is 11,704. Not all the cases of general disseminated tuberculosis affecting both kidneys have been recorded, but I have notes of 24, 7 of which (ex 1,020) were at the Victoria Hospital. It is interesting to note that disseminated tuberculosis may affect one kidney only. The right kidney only, in 16 cases, showed disseminated tuberculosis. The left kidney only, in 5 cases, showed disseminated tuberculosis. In one case was the disseminated tuberculosis situated in one kidney, the side not being stated. In all these cases there was disseminated tuberculosis elsewhere in the body. In only one case was one kidney (side not stated) involved by extension of tuberculous disease from abdominal lymphatic glands along the hilum of the organ. This method of involvement of a kidney is not uncommon in cases of malignant growth.

Local tuberculosis of any part of the genito-urinary tract is a not uncommon condition. There are notes of 60 cases, that is, ·5 per cent. (a little more) of all post-mortem examinations. These cases may be tabulated as follows:—

Local tuberculosis right kidney only, left kidney being healthy, 4 cases.

Local tuberculosis left kidney only, right kidney being healthy, 1 case.

Local tuberculosis right kidney only, left kidney showing ascending inflammation, 4 cases.

Local tuberculosis left kidney only, right kidney showing ascending inflammation, 2 cases.

Local tuberculosis right kidney only, left kidney showing disseminated tubercles, 2 cases.

Local tuberculosis left kidney only, right kidney showing disseminated tubercles, 1 case.

These cases have been grouped together as they certainly would have offered the best prognosis possible, if they had been operated upon at an early stage in the diagnosis; 16 ex 60, or 26·6 per cent. Many of the cases showed no symptoms, during life, of renal tuberculosis. That some of the cases were operated upon does not alter this question of operation for unilateral renal tuberculosis. Nephrectomy for tuberculous disease of one kidney is a formidable and severe operation.

Local tuberculosis of right kidney with tuberculosis elsewhere:—

Spinal caries, with double psoas abscess, 1 case.
Spinal caries and tuberculosis of the lungs, 1 case.
*Tuberculosis of prostate and disseminated tuberculosis, 1 case.
*General tuberculosis, 2 cases.
Tuberculous abdomen, 1 case.
Tuberculosis of cerebellum and meninges, 1 case.

Of these cases it may be said that a study of them would indicate that those marked with an asterisk could have been operated upon, with a good chance of success, whilst the condition remained confined to one kidney, that is, 3 cases, or 5 per cent.

Local tuberculosis of left kidney with tuberculosis elsewhere:—

Spinal caries, 1 case.
*Left vesicula seminalis and lungs, 1 case.
Knee and lungs, 1 case.
Tuberculous peritonitis, 1 case.
Lungs and bowels, 1 case.
*General tuberculosis, 1 case.
Tuberculosis of lungs and meninges, 1 case.

Of these conditions, the three cases marked with an asterisk could probably have been successfully operated upon, or 5 per cent.

With regard to the last case, it may be observed that there was right sided hydronephrosis, a condition which was possibly secondary to chronic pelvic peritonitis, and which would probably have precluded successful operation.

Local tuberculosis one kidney only (side not stated) with tuberculosis elsewhere:—

Tuberculosis of lungs and meninges, 1 case.
In two cases was local tuberculosis of the right kidney associated with renal calculi, and, doubtless, if these cases had been operated upon, disastrous results would have followed.
In one case there was a vesical calculus with caseous bronchopneumonia associated with right renal tuberculosis, and in another case with left renal tuberculosis. In the last case a successful operation might have been performed: 1 case, 1·6 per cent.
Local tuberculosis of both kidneys occurred in only 3 cases.
Local tuberculosis of both kidneys, with tuberculosis elsewhere, occurred in only 3 cases.

We may assume that these cases could not have been operated upon with success, that is, 6 cases, or 10 per cent.

Tuberculosis of both parts of the genito-urinary tract occurred as follows:—

With tuberculous disease elsewhere, and both kidneys affected, 4 cases.
*Local extensive genito-urinary disease, with symptoms for two years, 1 case.
*Tuberculous ureter bursting into peritoneal cavity, and giving rise to general peritonitis, 1 case.
*Local extensive genito-urinary disease, with 10 years' symptoms, 1 case.
*Local extensive genito-urinary disease, with one healthy kidney, 2 cases.
*Local extensive genito-urinary disease, with ascending inflammation only in one kidney, 2 cases.
Local extensive genito-urinary disease, complicated by stricture, 2 cases.

Those marked with an asterisk might reasonably have been operated upon with a fair chance of success had the surgeon been called in and acted early, that is, 7 cases, or 11·6 per cent.

There are five cases of genital tuberculosis, and only one case of primary tuberculous disease of the bladder, and this is not at all a convincing one.

Thus, roughly, 50 per cent. of these post-mortem cases might have been operated upon with a reasonable chance of success.

If we omit the cases of tuberculosis of the genito-urinary, and genital tracts, and of the bladder, we are left with 41 renal cases, and of these 22 might reasonably have been operated upon successfully, or more than 50 per cent.

These are post-mortem records, and if 50 per cent. of these cases could have been successfully operated upon, the proportion of cases at a clinique, general or special, should be very much greater. In this short, and dogmatic, summary I have not specifically mentioned affections of the ureter and bladder associated with genito-urinary tuberculosis elsewhere.

RALPH THOMPSON.

Annual Dinner of the Physiological Society.

THE Seventh Annual Dinner of the Society was held on January 16th in the College Reading Room. The President occupied the chair, and Dr. Kennaway, Messrs. Ryffel, Saner, Poulton, Merriman, and Abraham were present amongst a total of thirty-four members and guests.

Dr. Pembrey very kindly provided a surprise course in the shape of frogs' legs, which, after causing some slight initial anxiety, were greatly appreciated.

Speeches were made as follows:-

Toasts.—"The King," proposed by Dr. Pembrey; "The Society," proposed by Mr. Ryffel, reply by the Secretary; "The President," proposed by Mr. Saner, reply by the President; "The Vice-Presidents," proposed by Mr. Guinness, replies by Dr. Kennaway and Mr. Poulton.

Mr. E. A. Leviseur made a praiseworthy attempt to propose the Committee, but both the conclusion of his own remarks and the reply by Mr. McEvedy were unfortunately lost in the noise.

The musical programme, opened by Mr. Hirsch with a soothing solo on the flute, was carried through alternately with the speeches. Good songs were rendered by Messrs. Ryffel, Thompson, and Haskall, who were vigorously encored. A ragtime quartette, under the direction of Mr. Woodruff, performing on a relay system, was a great success, while Messrs Biddle and Guinness gave an excellent idea of the possibilities of ragtime clergy.

Following a duet by the brothers Leviseur, who produced somewhat varied effects upon the members, and are to be congratulated upon their coolness under fire, "Auld Lang Syne," sung with much vigor and feeling by those capable, brought a most enjoyable evening to a close, and it is hoped that the fun derived upon this occasion will give the needful stimulus to the keenness of those whose duty it will be to organize the gathering next year.

F. A. KNOTT,
Hon. Sec.

Guy's Hospital Debating Society.

A DEBATE, the subject of which was: "That in the opinion of this house Great Britain has passed the Zenith of her Power," took place in the College Smoking Room, on Saturday, the 16th of November. Some thirty members were present, many of whom took part in the discussion.

Mr. GUY NEELY, the proposer, opened the debate. In a short and somewhat rapid speech he attacked anything and everything with equal impartiality, beginning with the individual and ending with the State.

He pointed out that the Englishman of to-day could no longer boast that he could beat two Frenchmen, that the decline in agriculture, side by side with the growth of great cities, had adversely affected not only his physique, but also his general outlook on life.

He argued that our vaunted freedom was the excuse for indifference and lack of enterprise; that we were altogether wanting in discipline; that our education led to blind alleys, lack of employment, and consequent bad citizenship. In the latter part of his speech he proceeded to inveigh against the State, emphasising the fact that we had scarcely progressed while other nations had come quickly to the front. The power of a nation, he said, was its strength to make its influence felt in all the councils of the world.

He maintained that the days of Cromwell and Chatham has irrevocably passed, that we could no longer prevent wars by threat of offence, that relatively to other nations and to other periods of our history, our influence had declined. England had shattered the might of Spain, the power of Louis XIV., of Napoleon himself, now she could with difficulty guard her shores from attack.

Mr. KEMP, the opposer, promised to be his own reporter, with the result that one of the secretaries immediately fell asleep, while the other fell to sharpening his pencil for the next spasm. After a protracted pause he gave out that he had lost his speech. After such a long interval, we confess we have forgotten most of his arguments. That he spoke for over twenty minutes we remember, from the fact that he was called to order for exceeding the limit, which woke up one of the secretaries. That he spoke busily, good-humouredly, and pointedly, we infer from our knowledge of the man, but beyond that we remember little and apologise sincerely.

Mr. WICKENDEN, the seconder of the motion, began his speech rather slowly, but ended with a torrent of invective. As an example of polished English it was certainly unrivalled. His denunciation of the worldliness of the present day Englishman, of his sordid aspirations, of his utter soulessness and lack of character, was passionate in the extreme. At first his remarks were treated with levity; they appeared to be too highly coloured; but though one smiled at his metaphors, one felt the justice of his sentiments.

Mr. PEDLEY, the seconder for the opposition, also began somewhat haltingly; his notes seemed to handicap him by keeping him too rigidly to disjointed facts. It was only when he had lost his place that he treated the house to some delightful humorous touches. Occasionally, when he had given his imagination full play, he would stop for a word, and with charming insouciance ask the house to fill in the gap. He laid particular stress on the loyalty and devotion of the Colonies, and after having patted the house on the back, sat down amid applause.

Mr. MORGAN, in a very fluent speech, ridiculed Mr. Wickenden's remarks, and yet at the same time seemed to agree with the proposers of the motion. As a free-lance he gave satisfaction to both sides of the house.

Mr. HEATON, who spoke next, is always interesting. He speaks without notes and without the slightest hesitation. He deprecated the spoon-feeding tendency of the Government, and quoted Chesterton to substantiate his remarks. We failed to see the point of all his utterances, and he sat down leaving the house somewhat perplexed as to how he would vote.

Mr. LAYTON continued the debate. We are bound to confess without being in the least invidious that his speech was the best of the evening. He emphasised a deeper note, and perhaps added more dignity to the discussion. He was called to order for speaking away from the point by a certain member who revels in polite repartee, but apart from that spoke effectively for the motion. The gist of his remarks consisted in the careful analysis of the English character.

Mr. MILLER tripped up a number of previous speakers. After defining the motion, and showing to his own satisfaction, that most of the previous speakers had spoken through their hat, while the rest had spoken through the back of their neck, he proceeded, with a certain dry humour, to mystify at least his reporter.

Mr. STEVENSON quarrelled with Mr. LAYTON and sat down without giving himself away.

Mr. KEMP wound up the case for the opposition, and like many other members, speaks much more effectively on the spur of the moment.

The Proposer briefly replied. On a show of hands the motion was lost, 5 to 12.

A vote of thanks to Mr. Layton, the Chairman, was carried with enthusiasm.

Before the meeting adjourned, Mr. Layton urged men to be keen, and to induce their friends to turn up to the meetings of the Society. He emphasised the necessity for men to learn to speak, especially if they hoped to serve on committees or to make their views known in after life. Many familiar faces were absent; it is, perhaps, too much to expect all the men who have kept the Society going in the past to attend at every meeting, but until the attendance reaches a really passable figure the Secretaries would urge them to do their best to be present.

A DEBATE, the subject being: "That in the opinion of this house a successful doctor is necessarily dishonest," was held in the Club on Saturday, the 11th inst. Mr. A. R. Thompson was in the Chair. The discussion was characterised by short and somewhat unprepared speeches. In fact, only the opposer had really thought out his speech, bnt he was so distressed at the mover's briefness that he disdained to continue the discussion for more than a few short minutes.

The seconder of the motion could be seen two minutes before the commencement of the debate hurriedly preparing his speech. He was so disconcerted at being called upon five minutes later to speak, that he couldn't read his notes, and became incoherent.

The seconder of the opposition, beginning his remarks with the words "In conclusion, Gentlemen," was constrained to continue his speech by a faint cheer from the fireside, and subsequently warming to his subject

offered quite a good fight. An awkward pause supervened, whereupon the chairman called upon a man by the fire to add to the discussion. He, however, having woken up, knocked the ashes out of his pipe, and given all the symptoms of awakened interest, relapsed and fell asleep again.

The debate was continued in a somewhat desultory fashion until the chairman stepped down from the platform and began to talk. Nobody had done anything but define the words "dishonest" and "success." till he began to speak. In a very simple and direct manner he went to the heart of the subject; he discriminated between the money-making dishonesty, and the so-called professional dishonesty, which sought no end save the well-being of the patient. He cited many interesting cases to illustrate his remarks, asking the House to judge them on their merits.

It is impossible to report the utterances of some of the speakers, since the debate tended to degenerate into a form of question-and-answer discussion.

It is only fair to say that many of the regular speakers were up for examinations, while the proposer had only a moment's notice, and the seconder for the opposition took first place.

The briefness of the opening speeches detracted from the excellence of the debate, but the attendance was miserably poor. In fact, as the chairman said in a very excellent little speech. the lack of interest shown in the doings of the Society was almost a disgrace to the members of the Clubs' Union. Only twenty men were present, nine of whom voted for the motion, six against, the other five having disappeared previous to the division. A vote of thanks to Mr. Thompson was carried with enthusiasm.

Guy's Hospital Musical Society.

THE date for the second concert of the session has been provisionally arranged for April 6th. Owing to Mr. Dennis Browne's unavoidable absence the practices will not start till Friday February 7th.

It is practically hoped that Mr. Dennis Browne will be impressed by a keenness for the work (on the part of the men) which has hitherto been conspicuous by its absence.

The Society is to be congratulated upon procuring the services of such a worthy successor to Mr. Clive Carey.

H. Q. F. THOMPSON.
T. W. SHELDON.
Hon. Secs.

Trade Notices.

MESSRS. MAPPIN & WEBB have sent us their catalogue for inspection. It is a handsome volume and gives some idea of the enormous range of goods they offer. In the always baffling task of choosing a wedding-present the book should be of the greatest value; there is everything from jewellery to cutlery. We would confidently recommend the volume to sport secretaries and others who require cups and trophies in general. The presentation cups offer a selection which we should fancy is unequalled.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—ED., G.H.G.]

The Debating Society.

SIR,—We would like to draw attention to the deplorable lack of interest shown in the doings of the Debating Society. The debates are very meagrely attended, and the Society is fast sinking into a moribund condition.

At the last debate, held on Saturday, the 11th inst., twenty men were present. Not a single man representing the first, second or third year's entry put in an appearance, and the one man from the Dental Department, together with some ten more from the wards, exclusive of the committee, were barely sufficient to form a quorum.

When one thinks of the number of fellows who speak regularly at Physiological meetings, Dental meetings, Physical Society's meetings, etc., one wonders what becomes of them all on Debating Society's nights. It is not as though the subjects for discussion were chosen to suit any particular clique of men; on the contrary, the committee selected with great care subjects on which men of any year, and any opinion, could express their views.

If people who can and do speak at other societies would occasionally put in an appearance; if others who can't speak and are too modest, but who don't disdain to come and learn, would stand on their legs for two minutes and say something, we should total some hundred instead of a miserable twenty debate nights. There is nothing more absolutely chilling than a row of empty benches. Speeches are curtailed through lack of appreciation; insults provoke little or no resentment, for there is nobody to resent, and jokes fall flat. The few men who are present find it a tax to keep the ball rolling, while the debates are bereft of that enjoyment and keenness which characterise the discussions at meetings of other societies.

It is a poor compliment to the committee, who attend regularly and form a nucleus every month, and prepare all the speeches. It is a poorer compliment still to the Chairman, who never fails to turn up on the wettest of evenings and enliven the proceedings.

At each meeting the Secretaries have been urged to arouse some enthusiasm and bring back the attendances to a passable figure. We apologise for such a long letter, but sincerely hope that it may have the effect of bucking men up and proving that there is some life in the old dog still.

H. C. GODDING,
GUY NEELY, } Hon. Secs.

Dr. Pavy's Memoir.

SIR,—I have been reading with much interest Dr. F. Taylor's memoir of our late colleague, Dr. Pavy, in the Guy's Hospital Reports. It was as Lecturer on Physiology that I knew him best, but I do not think that a nervous manner was the cause of the interruptions and applause which frequently occurred at his very excellent lectures. On the other hand, I should say that he was extremely self-possessed, but that he lacked the sternness of character which compels obedience in class. The interruptions were never unkindly meant, as they were in the case of three successive lecturers on Botany, when the regulations required a course of attendance on lectures upon that subject. Rather, Dr. Pavy's manner indicated that he enjoyed applause, though it not unfrequently got out of control. His lectures were all given without notes and in such a deliberate manner that it was easy to take them down in a note-book almost word for word. He had a very distinct and definite mannerism, which might be thought pedantic. Thus, he never spoke of an animal's mouth, but always of its "oral orifice," and when making a chemical experiment for the completion of which shaking was necessary, he would say: "Our assistant will now proceed to agitate the liquid."

His lectures were frequently illustrated by experiments on animals which were anæsthetised by puff-ball, and when the experiment was finished he used to say: "We will now proceed to pith the animal," which meant that he was about to divide the medulla. This being done, he would turn to the audience with an air of satisfaction and say: "So now you see our dog is dead." These four iambics, indicating that the animal was released from life before recovering consciousness, were invariably followed by prolonged applause. But it must not be inferred that Pavy was a weak man who could not defend himself when attacked. This was anything but the case, and even in the last year of his life, when some juniors ventured to give their views on diabetes in his presence, I was informed that he rose to a high pitch of argument, showed up their ignorance, and laid them all flat on the floor. I was present at the lecture alluded to by Dr. Taylor, in which Dr. Pavy stated his preference for using dogs to cats for experiment. Dr. Taylor apparently quotes from the revised copy used for publication, but in the lecture given at Guy's he brought down the house by saying if his opponent "would hold the cat" he would be pleased to demonstrate the truth of his experiment on that animal as he had done on dogs.—Yours faithfully,

R. CLEMENT LUCAS.

DEAR MR. EDITOR,—In your always interesting columns I have noticed from time to time invitations to those who have been, or are still, in general practice to contribute to the GAZETTE. As one of the "has beens," I am sending you one or two of my experiences during my thirty years in the rank and file. One of my earliest calls was to a man who had hanged himself in a barn, and on arrival I found that the poor fellow was dead. At the inquest the man who first saw the man hanging, and who gave the alarm, was asked by the coroner: "Now, sir, you first saw the man hanging. Was he hanging quite still when you saw him?" "Oh, no, indeed, he worn't." The Coroner: "Oh, he worn't; then why didn't you cut him down?" to which the answer was, "He worn't dead!"

As an example of hysteria:—A lady brought her daughter to me, and said that she was quite sure that the girl was suffering from worms, and after a proper investigation I was able to tell the anxious mother that I was quite sure that this was not so. You can imagine my surprise a few days later on receiving a registered parcel by post containing a short note:—

> "Dear Sir,—You told my mother that I did not suffer from worms. Well, I enclose you one that I passed this morning.—Yours truly, X."

On examining this precious piece of evidence, a very useful leather bootlace was disclosed.

Very early one morning I had an urgent call to see a boy whose temperature was 108° F.; so the father said who came for me. I had two miles to go; didn't wait to dress, but put a dressing-gown over my night clothes and covered myself up with a rug. On arrival at the house the mother produced the thermometer, and sure enough it registered 108°, but the boy appeared to be very happy, and on taking his temperature myself it was normal. The mother had washed the thermometer in warm water before reading the index. Tableau!

I won't bother you with any more of this sort of material, but if you think it of any use, let me know.—Yours sincerely, OLD GUYITE.

Change of Address.

Fleet Surgeon W. J. Bearblock, R.N., from 7, Hoe Park Terrace, Plymouth, to H.M.S. *Bellerophon*, 1st Battle Squadron, Home Fleet.

Harold Chapman, L.D.S., from 20, Queen Anne Street, to 15, Upper Wimpole Street, W. *New Telephone No. Paddington 1202.*

Thomas Halliwell, M.R.C.S., L.R.C.P., from 115, Brockley Rise, to "The Rowans," Lowther Hill, Forest Hill, S.E. *Telephone 548 Sydenham.*

G. S. Hovenden, M.D., B.S., from Kitson Lodge to "Glebeholme," Barnes, S.W. *Telephone Richmond 1421.*

W. S. Kidd, M.B., B.S., from 24, West Street, Scarborough, to 54, Leeds Road, Harrogate.

H. Lee, to 49, Queen Anne Street, Cavendish Square, W.

M. K. Nelson, M.R.C.S., L.R.C.P., from 12, Belsize Avenue, Hampstead, to 1, Cherry Valley, Marlborough Park, S., Belfast.

E. Guy Robertson, L.D.S., from 25, Carlton Road to 27, Carlton Crescent, Southampton.

George Steele-Perkins, M.D., from 85, Wimpole Street, W., to "Woolloomooloo," Kingsdown, Deal.

Some Further Therapeutic Points.

An Address read before the Aldershot Medical Society on Friday, November 1st, 1912, by

HERBERT FRENCH, M.A., M.D. (Oxon.), F.R.C.P. (Lond.).

(*Continued from page 38.*)

The next therapeutic point that I should like to refer to is a very simple one indeed, but again and again it has proved extremely useful. It may be labelled:—

The Open-Eye Treatment of Simple Insomnia.—I have no idea to whom we owe the first insistence upon this point, but I have found that patients are very seldom told about it, so that one cannot but think that its importance is realised too little. When, without obvious external cause, such as too close a room, too many bedclothes or too few, a visceral pain, or some other cause of that kind, a person cannot get to sleep at night on account of what is generally called "simple insomnia," in the great majority of instances he lies in bed with his eyes tightly closed, restlessly rolling from side to side with all kinds of thoughts streaming through his mind and keeping him awake. It has always been an impossibility to me personally to count imaginary sheep passing through a gap in the hedge or to make any of the similar concentrated mental efforts that are so often prescribed, but I have always found it very easy, to begin with at any rate, to lie with my eyes wide open and if possible fixed upon some definite part of the ceiling or window or other point that may be just visible. In a very short time an increasing difficulty in keeping the eyelids up develops; the lids become heavy, but if one still persists in opening them to look again at the chosen spot as often as they tend to shut, it is surprising how soon oblivion supervenes. There are few things so soporific as a fixed intention to keep awake when one is in the dark, especially if the effort in that direction is accompanied by insistance upon keeping the eyelids open. Most patients are surprised at being advised to do what seems to them, in the first instance, the very opposite of what would appear the best course to follow, but when they try the effect they are generally delighted with it.

One other great point about simple insomnia is that it is seldom the insomnia itself which does so much harm as does the worrying at the fact of not being asleep. The individual lies in bed making a forced effort to sleep, and saying to himself how annoying it is his not sleeping like this; he has come to bed with the special object of getting a good night's rest because he knows he has a heavy day's work to-morrow; and now he cannot sleep; in a few minutes this worry grows upon him so much that he rolls from his right side over on to his left, and tries again in this new position. Before this has been given a proper trial he has decided that he will roll right over; and so he goes on; his restlessness increases, and by simply worrying at not sleeping he may successfully keep himself awake for two or three hours or longer. Many such patients have derived immense benefit from being told that the tired feeling next day is due to the worry at not sleeping more than to the not sleeping itself. It is possible to cultivate a sense of calm which assists the cure of insomnia without the use of any drugs. A man may lie awake all night, and it will do him no particular harm if he does not worry at it. If he persuades himself fully of this point and prepares to lie awake placidly all night he will often fall asleep in quite a short time, and much to his own surprise, especially if he adopts the "open-eye" remedy soon after he finds that he is not falling asleep in the ordinary way.

The next therapeutic point which I should like to draw your attention to is:—

The Value of the Skipping Rope in the Treatment of Chronic Constipation.

A very great deal of what may be called "chronic simple constipation" is actually the product of treatment by medical men. It is so easy to prescribe a laxative, or worse still, a purge, for a patient who complains that he is liverish and that his bowels do not act as well as he would like them to. The prescription is apt to be repeated. The patient may even be given a supply of pills to keep by him, one or two to be taken when he feels he needs them. The habit of taking them grows. Patients themselves often take purges in the form of proprietory pills without advice, and get into the way of depending upon them. Some parents prescribe purges for their children with too little thought. I do not wish to go into this point in all the detail that I should like, but I feel very strongly upon the subject of the abuse of purgatives and the tremendous amount of constipation and worse results that develop from it. I am accustomed to say that many persons who begin with cascara sagrada or Epsom salts at fifteen years of age have to take to calomel or podophyllin or something stronger at twenty-five or thirty, and have to increase the dose and the strength of what they need to move the bowels year by year until figuratively speaking in many instances at forty or forty-five, gunpowder will hardly do it. This, of course, over-states the case, except in the rarer instances, but there can be no doubt that a very great deal of chronic constipation, intestinal toxæmia and the protean results of this can be directly traced to the treatment of simple constipation by purgatives without first trying non-medicinal means. The first and most important of the latter is what may be called for short the cultivation of the regular habit, the patient trying to have his bowels moved each day immediately after breakfast, or at some other time if more convenient, but as far as possible at the same time each day until the bowels begin to get into the habit of wanting to be moved at this time rather than at any other. There are various ways of assisting the re-development of the diurnal habit of the colon. These have been ably discussed by Sir James Sawyer, M.D., F.R.C.P., F.R.S. Edin., in his work entitled "Practical Medicine." I wish, however, to lay particular stress upon one very simple accessory means of relieving chronic constipation, and that is the use of the skipping rope for sixty seconds after the bath in the morning, and if need be for another

Some Further Therapeutic Points.

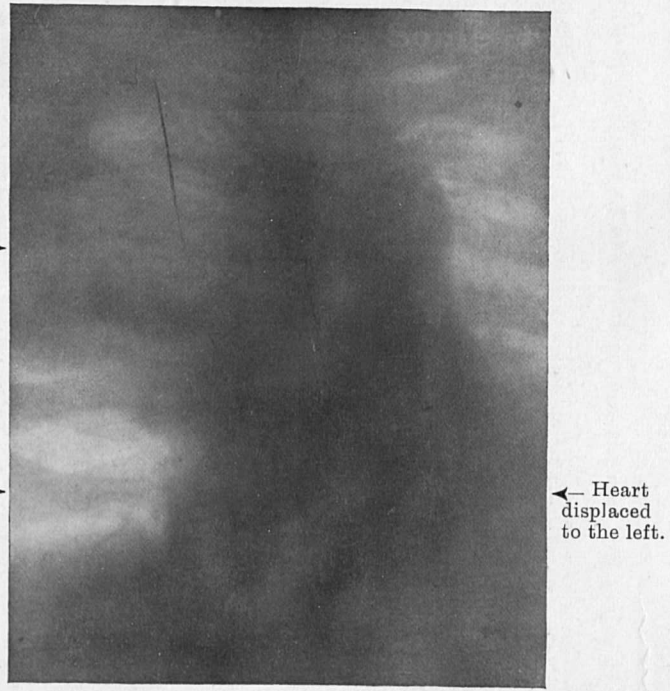

FIG. I.—Skiagram showing the pneumothorax at the right base, the heart displaced to the patient's left, and the right lung compressed and opaque.

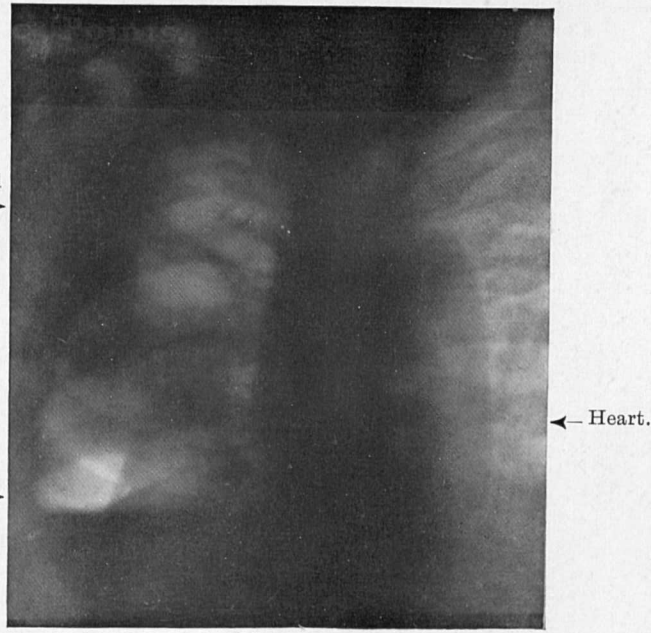

FIG. II.—Skiagram showing the condition a few minutes later, when most of the air had been removed from the pneumothorax by aspiration; the right lung has expanded considerably so that it is now again transparent in its upper half, the heart has returned nearly to its normal position, but there is still a small amount of air left in the right pleural cavity.

sixty seconds at some other period of the day. The vigorous jolting movements given to the whole body, the increased respiratory movements, the increased action of the heart, and the exercise given to the vaso-motor system in controlling the alterations in the blood supply produced by the exercise are all beneficial, except under exceptional circumstances such as definite heart disease and the like, but over and above this it seems probable that every time the patient skips over the rope, thus raising his legs off the floor, the sudden sharp contractions of the psoas and iliacus muscles directly influence the colon in front of them and thus assist the activity of the latter, possibly increasing peristalsis, especially in the cæcum and in the sigmoid colon. Very frequently the effort of skipping, even for so short a time as sixty seconds, causes flatus to be passed, showing that the movements have an immediate effect upon the bowel contents. The exercise occupies so short a time that it can be continued daily without any particular inconvenience or without its being omitted on account of its complexity or duration. Many individuals who have been sufferers from chronic constipation have found that the use of the skipping rope in this way, in addition to the cultivation of the regular diurnal habit, cures habitual constipation without the need for resorting to purgatives at all.

Turning now to a totally different condition, I should like to refer to

The rapid cure of Pneumothorax by Paracentesis controlled by X-ray observation of the Chest during the Operation.

I am speaking particularly of cases in which the pneumothorax is associated with relatively little disease in the lung itself, generally an early stage of apical phthisis. Patients of this kind are not common, but most of us meet with one now and then. It is good practice, as a rule, to leave the air in the pleural cavity for some weeks at least after the onset of the pneumothorax, and this for two reasons, namely, first, that by keeping the lung thereby at rest the tuberculous process within it is assisted in its healing, indeed, the rather drastic measure of inducing pneumothorax artificially in the treatment of phthisis that is not advanced is adopted regularly by some authorities; and secondly, because if one attempted to remove the air from the pleural cavity by paracentesis soon after the onset of the pneumothorax, the hole in the lung through which the air originally escaped into the pleural cavity would probably not have healed over sufficiently to prevent its re-opening under the strain of paracentesis. In four or five weeks, however, if the pneumothorax persists, instead of the air being spontaneously absorbed, there is a danger that the collapsed and compressed lung will become so fibrosed that it never will re-expand properly if active measures are not taken to cure the pneumothorax. When pus is present at the same time it is generally good practice to treat the condition as one would an ordinary empyema without a pneumothorax, and resect a rib for drainage of the chest. When air is present in the pleural cavity without fluid, however, or with only a small quantity of serous fluid, it is sometimes possible to cure the pneumothorax rapidly by paracentesis assisted by the X-rays. One of the cases so treated is recorded by Dr. John Fawcett in the Guy's Hospital Reports for 1907, vol. lxi., page 49, and Figs. I. and II. (see supplement) are skiagrams from a patient whom I recently had the opportunity of treating in the same way.

One uses the ordinary paracentesis trocar and cannula attached to the vacuum bottles that used to be employed in ordinary paracentesis of fluid. It is important to have two or three of these ready exhausted, and I am strongly in favour of the use of a powerful foot-pump for the purpose, because the smaller hand-pumps are so frequently inefficient. The patient either sits or lies according to the circumstances of the case and the exact position of the heart and of the compressed lung is observed by means of the X-rays and the fluorescent screen. The situation and the extent of the pneumothorax show very clearly as a rule. One inserts the trocar and cannula in the ordinary way, watching the contents of the thoracic cavity on the X-ray screen to ensure that the needle is well within the cavity of the pneumothorax and that it does not strike the lung beyond. On now opening the tap of the vacuum bottle, the air is drawn out from within the pneumothorax in exactly the same way that fluid is in the case of a hydrothorax, and one can regulate the rate at which it is thus evacuated by varying the degree to which the tap of the exhaust bottle is opened. The patient experiences very little discomfort, though he will presently begin to breathe more rapidly and say that he has a curious sensation, generally not acutely distressing, within his chest. One can see the compressed lung expanding as one watches it on the X-ray screen, and the heart can be watched coming back towards its normal position. As the lung is sucked out towards the end of the cannula, the latter is slowly withdrawn, and the direction in which its inner end is to point in order to draw out the last of the air can be observed easily on the X-ray screen. If the original hole in the lung through which the pneumothorax occurred has healed over so that air no longer escapes from the lung into the pleural cavity, it is possible in this way to draw off practically the whole of the air that has been in the pneumothorax, to re-expand the compressed lung until it again occupies its right position, and to restore practically to normal, except of course for the tuberculous or other disease in the lung itself, that which a quarter of an hour or twenty minutes previously was a serious pneumothorax. No anæsthetic is required. When all the air has been exhausted, the cannula is simply drawn out, and owing to the way that the skin and the cutaneous parts move upon one another there is no danger at all of fresh air escaping in through the chest wall from outside. It is not even necessary to apply a dressing. The simplicity of the treatment is as striking as is the benefit it gives.

(*To be continued.*)

We are gratified to announce that the sale of Christmas Greeting Cards amounted to £25 12s. 1d., which has been handed to the Hospital authorities, and thanks are due to Miss Smith and Mr. Crampton for their kind services in the matter.

Papers by Guy's Men.

Harold Chapple, M.C., F.R.C.S.: The Treatment of Pelvic Inflammation by Auto-Inoculation.—*Lancet*, 18th January, 1913.

J. D. Malcolm, F.R.C.S. Edin.: Gangrene of the Vermiform Appendix, and of a Coil of Small Intestine: Operation: Recovery.—*British Medical Journal*, 18th January, 1913.

N. Mutch, M.A., M.B., B.C., and J. H. Ryffel, M.A., B.C., B.Sc.: The Metabolic Utility of Rectal Feeding.—*British Medical Journal*, 18th January, 1913.

L. W. Reynolds, M.R.C.S., L.S.A.: The Treatment of Obstinate Sciatica by Phenazonum Injection (Memorandum).—*British Medical Journal*, 25th January, 1913.

Graham Simpson, F.R.C.S.: The Treatment of Fractures about the Elbow Joint.—*Clinical Journal*, 29th January, 1913.

H. F. B. Walker, M.D.: Hydatid of the Submaxillary Gland (Memorandum).—*British Medical Journal*, 18th January, 1913.

W. Hale White, M.D. Lond., M.D. Dub., F.R.C.P.: A Clinical Lecture on Myxœdema, delivered at Guy's Hospital on November 20th, 1912.—*Lancet*, 18th January, 1913.

A. Read Wilson, M.D. Oxon.: Some Rarer Manifestations of Parasyphilis of the Nervous System.—*Brain*, Vol. xxxv., Part II.

Appointments.

Royal Navy

Staff-Surgeon C. H. Dawe has been appointed to *Vivid*, and for disposal to be lent to the *Indus* temporarily.

Staff-Surgeon W. P. Walker has been appointed to *Queen*, additional for 2nd and 3rd Fleets.

Surgeon H. M. Langdale to *Victory*, additional for disposal and to *Zealandia*.

R.A.M.C.

Captain A. L. Foster has been appointed to the Station Hospital, Rawal Pindi, on transfer from Kalabagh Cantonment, Murree Hill District.

Lieutenant P. C. Field has been transferred from the Military Hospital at Cairo, to Alexandria for duty.

Lieutenant V. P. Hutchinson on arrival in the South African Command has been posted to the Military Hospital, Pretoria, for duty.

Lieutenant A. G. Jones, on arrival in India, has been attached to the Station Hospital at Rawal Pindi, for a course of instruction in Indian sanitation.

I.M.S.

Major E. J. O'Meara has been selected for appointment as a Fellow of Allahabad University.

Captain H. Watts, Officiating Civil Surgeon at Wardha, has been transferred to Betul District as Civil Surgeon, and for Executive and Medical Charge of Betul District Jail.

Lieutenant C. A. Wood has been appointed to act as Civil Surgeon, Jacobabad, from 15th August, 1912, in addition to his own duties.

Civil.

W. P. Noall, M.S., F.R.C.S., has been appointed Honorary Consulting Surgeon to Brooke Dispensary and Cottage Hospital, Selby.

D. Wilberforce Smith, M.B., B.S., F.R.C.S., has been awarded the Emden Scholarship in the Cancer Research Laboratories, Middlesex Hospital.

Pass List.

University of Cambridge.

The following degrees have been conferred:—
M.B., B.C.—W. T. Chaning-Pearce.

University of London.

Third Examination M.B., B.S. Degrees.
Addendum to Pass List.
Glendining, V.

Conjoint Board.

First Examination, January, 1913.

Part I.—Chemistry.	Part II.—Physics.
Green, P.	†Hearnden, W. R. G.
†Harrington, F. J.	Pryn, R. H. C.
	Simons, G. E. L.

†Passed in Part II only.

Part III.—Elementary Biology.

Fasken, N. E.	Pryn, R. H. C.
Hearnden, W. R. G.	Simpson, B. C. W.
	Vincent-Brown, C.

Part IV.—Practical Pharmacy.

Jones, D. W.	Penny, C. H. G.

Second Examination, January, 1913.
Anatomy and Physiology.

Bates, K. L.	Gibson, C. C. G.
Clark, J. E.	Gripper, G. D.
Coffin, S. W.	Holmes, R. A.
Curle, R.	Rook, A. F.
Easton, W. A.	Staley, R. C. W.
	Stevens, J. G.

Royal College of Surgeons.

LICENCE IN DENTAL SURGERY.
Preliminary Science Examination, January, 1913.

Part I.—Chemistry.	Part II.—Physics.
P. E. Bernhard.	S. Sanders.
F. W. Crook.	D. F. Small.
P. J. Hugo.	M. C. V. Thom.
W. J. Pretorius.	P. L. van Schalkwijk.
R. J. Ryland.	S. A. Woolf.

Society of Apothecaries.

Anatomy.
G. Noott. J. Totton.
Physiology.
G. Noott. J. Totton.

Association Football.

GUY'S v. OLD WILSONIANS.
2nd Round Surrey Charity Cup (Replayed Tie).

This match was played at Beckenham Hill on December 14th, 1912. The teams had already met at Honor Oak Park, where the match resulted in a draw of 2 goals all, and a close game was anticipated. Guy's won the toss, and played with a strong wind behind them and downhill. The play was carried into the opponents' half and remained there most of the first half. Guy's continually shot at goal, but the wind made it very difficult to control the ball. H. V. Stebbings placed the ball well in front of goal from several corner kicks. Guy's could not score for some time, and at last J. M. Stebbings scored with a beautiful shot from 20 yards range. Just before half-time Cox headed a goal from a corner kick. The teams crossed over Guy's leading by 2 goals to 0.

The Wilsonians began to press on resuming, but fine defence kept them out for quite twenty minutes. Biddle kicks the ball very well, and keeps it low. Guy's got the ball going and pressed for five minutes. H. V. Stebbings was unlucky in shooting over the bar. The Wilsonians scored by their centre forward, and about a minute afterwards they added another, thus equalising. About five minutes from the end of the game Rook failed to stop a high centre from the left wing which just passed under the bar in the right hand top corner. The Wilsonians added a fourth and doubtful goal just before the whistle blew. Guy's were thus beaten by 4 goals to 2. Team:—

GUY'S.—H. C. Rook (goal); K. J. T. Keer, F. J. Biddle (backs); L. Gill, J. Kyle, D. A. Bevis (halves), Pickett, C. Coxon, R. M. Veale, J. M. Stebbings, H. V. Stebbings (forwards).

GUY'S v. EVERSLEIGH.

This match was played at Eversleigh on Saturday, January 25th. Guy's played Kyle at back owing to Keer no longer being available. D. A. Bevis went to centre half. The ground was very muddy near the goal at one end, and made the game difficult for accurate passing. Guy's began to press, and H. V. Stebbings ran through and scored from a pass by his brother. Coxon headed in a centre from J. M. Stebbings past the goalkeeper. Cox, who was playing at outside right, got away and centred in front of goal, but their backs cleared. J. M. Stebbings dribbled through and scored with a fine oblique shot, and just before half-time H. V. Stebbings ran through again and scored with a good shot. Guy's led at half-time by 4 goals to 0.

On resuming, Cox got away, and put across a good centre, from which H. V. Stebbings scored. Cox put in a very hard shot from a back pass, which the goalkeeper tipped over the bar. Eversleigh scored about ten minutes before time with a good shot from a break away. Just before time H. V. Stebgings scored again, but this time the goalkeeper was at fault. Guy's won by 6 goals to 1. Team:—

GUY'S.——. Welton (goal); J. Kyle, F. J. Biddle (backs); R. M. Veale, D. A. Bevis, L. Gill (halves); J. R. Cox, C. Coxon, H. V. Stebbings, J. M. Stebbings, —. Staley (forwards).

REMARKS.—The team played very well considering the state of the ground. Gill kept his wing men under control, and they hardly got away at all. Veale played a good defensive game at half, while D. A. Bevis at centre half was everywhere. The forwards played well. The two Stebbings played quite their best game together this season, and Cox did everything he had to do in excellent style. The backs were not tested very much.

Rugby Football.

UNITED HOSPITALS v. THE ARMY.

This fixture was played at Richmond on Wednesday, January 15th, and ended in a runaway victory for the Soldiers. There was one crumb of satisfaction in the fact that Lieut. Huggan, who played extremely well on the right of the three-quarter line, is in the R.A.M.C., being a graduate of Edinburgh. The Hospitals were beaten forward, Captain Craven having at his command a very heavy eight. As a consequence Broster, at the scrum base, was frequently overwhelmed, so that the men behind him had limited chances. The Army scored first through Huggan, and next Gordon sent Cransmore in, but Lindow should have stopped this effort. A little later, Broster cut out a nice opening for Palmer, who scored, and made an excellent attempt to convert. This was, alas, the only score for the Hospitals. The Army backs were constantly on the move, and although a heavy hail and snowstorm came on midway through the play, they still handled and ran in splendid style. Stewart tried his utmost to get going, but he was pressed to the line constantly, almost before the ball reached him; but he did good work in defence, marking Cransmore effectively. The Army led at half-time by 4 tries to 1 try.

During the second half the scoring was kept down, until about fifteen minutes from the end, when 3 more tries were added to the Army score. Two were converted, so that the final score read: The Army, 2 goals 5 tries (25 points; Hospitals, 1 try (3 points). Team:

UNITED HOSPITALS.—E. D. Lindow (King's) (back); G. A. Lilly (London), H. G. Morriss (London), A. C. Palmer (London), W. A. Stewart (London) (three-quarters); L. R. Broster (Guy's), C. H. Medlock (Guy's) (halves); W. C. Hartgill (London), H. A. Crouch (London), C. M. Chapman (London), O. Parry-Jones (Guy's), A. L. Liebson (Guy's), R. Kitching (Bart.'s), H. L. Hughes (University), J. S. Sloper (Thomas's) (forwards).

GUY'S v. OLD MERCHANT TAYLORS.

There was plenty of mud at Honor Oak Park on January 18th for the above match, but the condition of the ground did not prevent a very fine game, somewhat interfered with, perhaps, by the many "whistlings" of the referee, who interpreted the rules with great strictness and rigidity. One almost hoped the mud would have penetrated to the whistle, especially when the official was once accidentally knocked to Mother Earth. But for all that many of us would have done much worse, perhaps, in his place; so we must be thankful there are such good sportsmen to undertake a task that few thank them for.

The finish was exactly as it should have been—a draw. Both sides played well; it was a day for forwards, and the individual packs strove hard for the upper hand. It looked as though Guy's would gain this, as one very fine rush after some fifteen minutes' play took the ball close to the Taylors' line, where Harkness came up and seemed to have scored, but he was ruled offside. From the drop-out the Taylors' forwards got to the other end, but strenuous tackling prevented a score. So, with varying fortunes, the first half was played through.

The second half was very similar. Greenhill, playing outside left for the Taylors, did some good fielding. An excellent bout of interpassing by the visiting three-quarters looked very dangerous till Millett tackled Greenhill. Roberts led the forwards in great style. It looked as if they must score when only about ten minutes remained for play. The forwards got quite to the line. After a time Medlock got the ball to Harkness, but the last-named punted, and Allen got to the ball and cleared for the Taylors. Nothing further of interest took place, and a close game ended with a clean score sheet. Team:—

GUY'S.—H. Millett (back); F. A. Knott, G. B. Pritchard, A. H. Harkness, C. L. Curle (three-quar-

ters); A. F. Rook, C. H. Medlock (halves); C. S. L. Roberts, W. S. Stranack, M. Tweed, A. W. H. Davies, H. P. Whitworth, A. L. Anthony, M. B. Haines, L. Llarena (forwards).

REMARKS.—Any player at all likely to be called on for the Cup Ties should do his utmost to get and keep fit. This is one of the most essential things to ensure success. The last twenty minutes often wins or loses the game. Guy's have, the last year or two, taken great pains to train properly and thoroughly, and it is hoped this year will be no exception. Hearty congratulations to J. P. Jones on being chosen to play for Wales. No honor is more richly deserved, and all Guy's men will rejoice that so loyal and able a player has gained the highest recognition from his country.

Hockey.

GUY'S v. GUILDFORD.

Played at Guildford, on Saturday, January 18th. Guy's won by 7–0 after playing their best hockey this season.

We were strongly represented, and the three reserves who turned out were exceedingly good. Jessop at centre was in good form but should practise passing to the right more. His passing to Bromley, however, was very good, and he took Poulton's place at centre very well. The two reserve backs, Lee and Cutts, were splendid. Lee has not played hockey for seven or eight years, but he was very safe on Saturday, and Cutts cleared well, too. Of the others, Coxon in goal was good, but was not tried very severely. This was not because our opponents were weak, but because Jackson and Smith were at their very best and gave the forwards no chance of getting into the circle. These two halves were, perhaps, the best men on the field. The forwards also were very good, and have never before shown such good combination and splendid dash.

Vincent-Browne opened the scoring ten minutes after the start with a good shot. Graham added another and Bromley a third, so that we crossed over leading by 3–0. Soon after the re-start Bromley added another. Then our opponents' left inside was crocked, and this allowed Purdom to go up still more with his forwards. The opposing halves were also tiring and with Guy's pressing harder than ever, we scored three more goals through Bromley, Graham, and Vincent-Browne. The game was tremendously fast and clean and was much enjoyed by both sides. R. C. Matson and A. H. Birks were among the spectators; the latter is now at Guildford Hospital.

A. Crowe—a present Guy's man and member of Guildford team—played a very sound game at back for the losers. Their goal-keeper was also very good and saved many hot shots from the forwards. Team:—

GUY'S.—A. C. M. Coxon (goal); H. Lee and C. L. Cutts (backs); C. R. Smith, R. W. P. Jackson, and H. N. Purdom (halves); C. Vincent-Browne, L. Bromley, P. E. Jessop, L. A. Graham, and J. H. Parry (forwards). *Referee*—Mr. J. Crosbie, S.C.H.U.A.

INTER-HOSPITAL TOURNAMENT.

Guy's met King's College Hospital in the first round of the above tournament on Monday, January 20th. The game was played on the mid-Surrey and Ealing's ground at Richmond, and in spite of recent rains, the turf was in very good condition. Guy's pressed from the start and after two or three good but fruitless attacks, Graham scored a good goal. Continuing to do all the pressing we scored another goal through Bromley, and then came the best goal of the game. Jackson had relieved pressure and passed to Bromley, who sent out to Vincent-Browne. It was promptly centred to Poulton, and he and Graham took it right through into the circle, passing backwards and forwards until, from a perfect pass from the latter, Poulton scored a clever goal. The passing between the forwards was very good and characterised the play of the first half. Four more goals were added by Bromley, Poulton, Graham, and Parry. All of these were good shots and several others would have scored but for the clever saving of the King's goal-keeper. Having scored seven goals while playing up the slope, Guy's were inclined to slack the second half. Added to this was the fact that we had hardly fully rested from our hard and fast game against Guildford. Also, with our opponents packing their goalmouth, the forwards found it very difficult to get through, although Parry scored towards the end with a good shot, which, however, was disallowed because of a doubtful "sticks" infringement. Just before this, King's had scored once through Negas, their inside right, who was their best man. Had Guy's been at all hard pressed they would no doubt have worked harder in the second half. As it was we won very comfortably, and our display in the first half was exceedingly good, the forwards being quite brilliant. We were at full strength except for Morgan at back. Team:—

GUY'S.—A. C. M. Coxon (goal); G. D. Gripper and R. C. Matson (backs); C. R. Smith, R. W. P. Jackson and H. N. Purdom (halves); C. Vincent-Browne, L. Bromley, E. P. Poulton, L. A. Graham (Capt.), and J. H. Parry (forwards).

We are due to meet the winners of London v. University in the next round, and the date will probably be Tuesday, February 11th.

Our match v. King's College on Saturday, January 25th, was scratched by them owing to the ground being unfit.

Births.

STEINBACH.—On January 16th, at Newton House, Knaresborough, Harrogate, the wife of Horace Steinbach, M.R.C.S. Eng., L.R.C.P. Lond., of a daughter.

Marriages.

MESSENT—GIBSON.—On December 16th, 1912, at Union Church, Brighton, by the Rev. T. Rhondda Williams, Rupert J. Messent, L.D.S. Eng., to Elsie May Gibson, daughter of the late Mr. W. R. Gibson and of Mrs. Gibson, of Hove.

Old Guy's men will be interested to learn that on January 11th, 1912, Miss Dorothy Wooldridge, B.A., the only daughter of that brilliant physiologist, Dr. Leonard Wooldridge, who at the time of his death was Assistant Physician to Guy's Hospital, was married to Captain W. H. Thring, R N. He is at once proceeding to Australia, where he has an important post in connection with the founding of the Australian Navy, he being first naval member of the Commonwealth Board. His wife goes with him.

Death.

DALLAS.—On November 9th, 1912, at Ealing, W., Deputy-Surgeon-General A. M. Dallas, Bengal Medical Service (Retired), aged 80.

Ed.—F. G. L. S.

GUY'S HOSPITAL GAZETTE.

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Passim.

WE make no excuse nor apology for putting in the forefront of this Magazine a votive offering for the success of the Rugby team in the inter-hospital competition. The first match will have been played between going to press and publishing, so we will refrain from prophecy.

So far the season has not been so successful as usual. Of the eighteen matches played eight have been won, nine lost, and one drawn. The best victory was without doubt won against Oxford a few weeks ago; but the draw against the Old Merchant Taylors was decidedly a good performance. We may in some degree attribute our want of success in the earlier part of the season to the fact that, from one cause or another, the full team could not be got together. But since Christmas it has generally been possible to put our best side in the field and the results have been more satisfactory; moreover, the arrival of L. R. Broster, from Oxford, has strengthened us considerably.

As regards the team—our chief weakness lies in the three-quarter line. At full-back and half back we are excellently served, and the forwards show every sign of being a formidable pack. But for sixpence we cannot foretell the future for our readers; elsewhere they can have it for the modest sum of one halfpenny.

To imagine himself in a lecturer's chair is a difficult thing for the student: so difficult that we fear he rarely makes the attempt. If he were to do so occasionally it would probably be good for lecture, lecturer, and indirectly for the lectured. The value of lectures from the educational point of view comes frequently under discussion, but though there is much divergence of opinion, the general feeling seems to be that, while routine lectures may not be an unmixed blessing, clinical lectures are, as a rule, very profitable. This being our view of the case as well as, we think, that most widely held, we should like to suggest that some differentiation in the respect shewn for the two types of lectures is justifiable, though not at present apparent. We are not concerned with the time-honoured custom of departing from routine-lectures at the earliest possible moment, but we should like to protest against similar behaviour in the case of Clinical lectures. Apart from the fact that they treat of special subjects, cases, or aspects of disease, and are, for that reason, of peculiar interest and value, Clinical lectures usually merit a good attendance and careful attention because of the great care and trouble which has been expended in their preparation. Further, in view of the fact that they have been so arranged as to interfere as little as possible with other Hospital work, there can be little excuse for the somewhat contemptuous treatment which they frequently receive.

IT must be intensely annoying and not a little disconcerting for the lecturer when a considerable proportion of his audience gets up and walks out, and perhaps still more so when it departs

"in single spies" and driblets instead of "in battalions." Although we realise that this disrespect is unintentional, we also maintain that it is unnecessary. If a man knows that he has an engagement elsewhere during a lecture-hour, he should not go to the lecture. If he does go, it is his duty for his own welfare, and in the cause of decency, to remain until the end. As a general rule it will be found that the excellence in delivery of a lecture varies directly with the size of the audience, so that an appeal for better attendance at Clinical Lectures may well accompany our appeal for better attention during their delivery. The slightly increased expenditure of time will bring its own benefits.

Speaking of lectures, by the bye, Dr. Weisenburg, of Philadelphia, is advocating the Cinematograph as a medium for teaching the signs and symptoms of disease. The machine has lately been used to depict various surgical operations, and to illustrate the appearance and growth of bacilli; so there seems no practical reason why the chest movements in various lung and heart conditions should not be shown, as he suggests, by this means, and indeed nervous or other cases in which gait and movement are peculiar. But the idea is chiefly, we fear, to capture the errant interest of the student. If the valley of the shadow of education is to be lighted by such a torch it is rather a confession of the timidity of the travellers therein. Science runs the risk of becoming too luxurious now-a-days.

The Dental Department has recently become so much larger and more complex that the appointment of an officer who should be able to devote several hours daily to its administration has become essential. Mr. F. B. Bull has been elected Resident Dental Officer. We offer him our hearty congratulations.

Admirers of Mr. Wingent's Cartoons will be interested to learn that a second collection of his drawings is about to be published. Like the earlier volume of 1910, it is to include numerous Gazette Cartoons, and various Hospital programme designs.

The Annual Dinner of the Guy's Hospital London University Club will be held on Friday, May 2nd, in the Criterion Restaurant, at 7.30 for 7.45. The President, Mr. F. F. Burghard, will take the chair. All past and present London men who are, or have been at Guy's, are invited to come, and it is hoped that there will be a record attendance. Further information may be obtained from the Hon. Sec., Dr. C. S. Medes, 7, Cumberland Terrace, W., and Mr. W. E. Tanner, Guy's Hospital.

Owing to pressure on our space we have been obliged to curtail our Sports column; also a report of the Debating Society's last meeting.

F. G. L. S.

University of London Officers Training Corps.

"B" SECTION. MEDICAL UNIT.

Company Orders and Notices.

1. Captain J. McKenzie, R.A.M.C., is attached to the contingent under Par. 48, Regulations O.T.C., until March 3rd, and holds classes as under for Cadets entering for Certificates A and B of this section.

Tuesdays, at St. Bartholomew's, at 5 p.m.

Fridays, at Guy's, at 5 p.m., in No. 2 Class Room, Physiological Block.

2. Written examinations for Certificates A and B will be held at the University of London, Monday and Tuesday, March 3rd and 4th, 1913.

Oral examination for Certificate A will be held at St. Bartholomew's, at 4.30 p.m., on Tuesday, March 3rd.

3. The undermentioned Cadets having been enrolled on the dates mentioned are assigned numbers, as under:

3461. Clarke, A. H. (St. Thomas's), 1st February, 1913.
3462. Terry, J. N. (St. Thomas's), 1st February, 1913.
3463. Ware, S. A. T. (St. Thomas's), 1st February, 1913.

4. The following re-engagements have been approved:

Cadet-Serg. C. W. Sparks.

Cadets A. B. Bond, H. St. C. Hamilton, C. Y. Roberts, G. C. Robinson, W. L. G. Reynolds.

5. The following scheme of drills has been drawn up for drills on Thursdays, at 4.30 p.m., during the present term:—

Each day.—Stretcher drill. The Superintendent has given permission for this to be carried on in the Colonnade adjoining the Anatomical Department.

February 20th.	Field Service Regulations, Part I., Chaps. II. & IV., Inter-communication, Orders and Billets.
February 27th.	Do., do., Chap. III. Movements, Route Marching, Hygiene.
March 6th.	Bandaging and First Aid. Field Cooking.
March 13th.	Water Supply.
March 20th.	Field Medical Units.

In addition, recruits should attend drills at 4.30 p.m. on Tuesdays in the Old Surgery, St. Bartholomew's Hospital.

6. A Staff Ride will take place on Saturday, March 15th, all attending will bring bicycles. The district will probably be in Kent, near by Bromley. The exact place and times will be arranged shortly. Will anyone intending to come give in his name to Cadet Lance-Corpl. Gripper, or Cadet Biddle, before Thursday, February 20th. The scheme will be explained to men taking part in it about a week before the date.

T. B. LAYTON, Lieut. R.A.M.C. (T),
O.C. "B" Section.

An X-ray Couch.

MANY old, as well as present, Guy's men are interested in the selection of X-ray apparatus, and one is frequently called upon to advise in this connection. Perhaps, therefore, the following remarks will be admissible to the GUY'S GAZETTE.

A few years ago the source of high tension current would have taken a prominent part in an article of this description, but for reasons hereafter given the couch is chosen as being by far the most important item for discussion.

The quality of coils, interrupters, rotary high tention transformers and tubes has of late years so much improved that there is little need of an analytical survey, but when the method of applying the rays to the patient is considered, the matter is not one on which one can congratulate the instrument maker.

The first essential, as in all other forms of diagnosis, is that the operator shall, as far as possible, be able to concentrate his whole thought upon the one subject. Unfortunately, the complications and difficulties connected with the running of an X-ray tube are so many and various that complete attention to the lesion under examination is often difficult. It is, however, possible by carefully thought out devices to make an examination, at any rate for minutes at a time, in ease and comfort.

Let us consider what we are striving to attain.

The tube—the source of X-ray light—is giving off in all directions (but mostly from one part) rays of both utility and danger. It is of first importance to baffle the latter.

After much trial (and many errors with disastrous consequences), it has been found best to place the tube in a box which is completely covered (except for an opening in one place) with an X-ray impervious material. The opening is opposite the most luminous part of the tube, and allows the escape of the rays useful for diagnostic purposes.

This opening is modified by either a simple diaphragm made of one-eighth inch lead plate with a suitably sized hole in it—square or round, as many of these diaphragms being kept as is considered necessary (for example, for chest work the full opening or a large diaphragm may be desirable, for renal work a small or very small one may be required); or an adjustable diaphragm such as an "iris" can be used; but owing to the extreme clumsiness of these mechanical diaphragms, if made of material thick enough to be efficient, there can be little doubt that the simple lead plate is the better. It would seem of interest to consider for a moment the evolution of the X-ray couch, and, as one who has been instrumental in bringing into vogue the system of using the tube beneath the couch, I append a few details.

In 1897, a few months after the discovery of the X-rays, when all screening was done in a vertical position with open tubes, and patients lay on plates on a couch when photographs were required, the editor of the "Archives of the Rontgen Ray" gave a demonstration at the Miller Hospital on a new method of screening. The patient lay upon a long wooden kitchen table, the tube was placed in its holder a few inches above his foot, and we lay on our backs under the table and held a screen above our heads. One remembers with what haste one came back to Guy's fearful lest the inventor of this ingenious system should see fit to invert the position of operator and tube before one could get one's own ideas into wood and canvas.

As a preliminary step, one fixed a stretcher on two chairs, and put a tube in a little holder underneath and moved it with the foot, and, primitive though this sounds, it increased the usefulness of the X-ray Department by 50 per cent.; furthermore, it was possible to photograph by placing a plate under the screen instead of pushing it beneath the patient, and adjusting a tube above him in the "jab and trust to luck" method then prevalent. In the meantime, one made a couch which carried the tube in a wooden holder and slid on rails, and this was copied by the hospital carpenters. The top was of canvas. When this innovation was written up, it was not received very readily, the most absurd criticisms being made. Then Mr. Dean, the well-known instrument maker of Hatton Garden, came to my help, and soon a much improved form was brought out, the faults being chiefly the non-protection of the operator and the inability to move the tube in any but two directions. Later, one drew up a much more elaborate couch, and offered the designs to the Sanitas Electrical Co., in consideration for which they gave me two couches, one for my own use, the other for Guy's. This, by means of sprockets and chains, gave up and down, side to side, and end to end movements of the tube box (the last an innovation). Also, the box could be tilted to any angle, an immense advantage. Then, the top was removable as a temporary stretcher, and a long footboard low down in front worked two switches so that downward pressure opened one and closed another, upward pressure doing the reverse. Thus, a quick downward tread with the foot when standing near the couch would turn on the room lights and turn off the primary current, and so the rays.

There is no doubt but that this was a most impressive affair, and one received well-earned reward by congratulations and an excellent notice in the *Lancet*, the effects of which were only marred by the contrivance turning out a nearly complete failure in practice. Although made of dry wood of generous proportions, and giving the impression of insulating properties above reproach, the subtle ramifications of

metal work, seemingly devised to pick up each and every strayly induced current, proved a means of nerve shattering torture to the operator; and when, as was often the case, they delivered their concentrated and pent up energies *at* the operator *via* the patient, the result was scarcely one to encourage mutual respect.

The prospect was somewhat hopeless. One could not get another firm to make a different pattern couch, as this would have been manifestly unfair to the Sanitas Electrical Co., and, as a compromise, tubes of sufficient softness were used to lower the general potential of the high tension current, and for some years this was fairly successful. Scarcely a day, however, passed but someone got a shock when in a moment of enthusiasm he thought he saw something upon the screen that was of interest, and approached too near to couch or patient. To this day traces of these terrors are observable in certain people who keep a respectful distance while others are pressing forward.

However, one learnt much from this failure, and when the Snook type of apparatus came to the front another opportunity occurred for redesigning this important piece of apparatus. This old couch could only hold a small type of tube 12 to 15 inches long, while the modern generator was demanding a tube 2 feet long. Then the increased quantity of high tension current changed the nature of the accidental shock from unpleasant to dangerous.

It became evident that insulating material only could be used in the neighbourhood of the tube, and that if metal were employed it should be in the periphery of the couch. In the old couch the contrary state of affairs prevailed. After exhaustive tests of wood, glass, vulcanite, fibre, etc., wood was found to be the most satisfactory, and after trying several varieties of hard and soft woods, dry yellow pine, soaked or boiled in paraffin wax and varnished with shellac, proved efficient. Tube box runners and cross rails were made of this.

Now came the method of bringing this dangerous current from generator to couch without fear of accidental contact. Hitherto wires had been employed, and proved very unsatisfactory; loose wires are a continual source of irritation.

The difficulty was overcome by mounting brass tubing on wooden rails beneath the tube box longitudinal rails, and picking up the current with brass shoes which dragged on the top of the rails. These conducted the current up to the wooden cross rails, and from here by means of telescopic rods it was conveyed to the interior of the box, where broad flat springs formed the terminals.

In the old couch the changing of the tube was a matter of time and difficulty; consequently if a tube got hot during an examination it often had to be run on to destruction, whereas to have changed it for a cool tube would have been a measure of economy.

Bearing in mind this fact, the following device was constructed: A small cage (Fig. I.) in which the

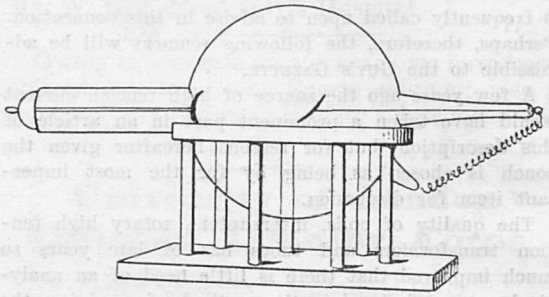

FIG. I.

tube lay and was comfortably supported and fitted into the tube box in such a way that the tube automatically made contact with the before-mentioned flat springs. Several of these cages being at hand, a new tube could be slipped in in a moment, loose wires and a tube holder being superseded. With a short length of belting the operator moved the tube by means of a motor car steering wheel and a suitable system of pulleys from side to side of the couch. Also the longitudinal travel of the tube box was provided for. Now came two important movements:—

1. Bringing patient and tube nearer or farther from one another;
2. Altering the angle of the rays in relation to the patient.

These were managed as follows: The outside structure of the couch was made of steel tubing, being the lightest and strongest material available. The wide stretcher on which the patient lay was also of steel tubing, but detached from the rest of the couch. In each of the four uprights a screw, with a quick thread, was worked, on which travelled a gunmetal nut with a lug which supported one corner of the stretcher. These were coupled to work together in pairs, one pair each end of the couch, by bevel gear, so that by turning a small motor-car steering wheel either end of the stretcher could be raised and lowered. This gave us the two movements (1 and 2) required.

Incidentally by putting a lashing at each end of the front corners of the stretcher, and then lowering the stretcher, the front side would remain up and the further side fall, thus providing a sideway tilt, the most desirable position for examining œsophageal cases, as gravity does not interfere with the results as in the vertical position.

Finally, the long footboard switch was retained in an improved form. When this couch was complete, one was tempted to publish a description, as it did not seem to have any weak points, but one decided

not to be caught again, and gave it a two years' test. Except for several small pieces of bad workmanship, which have been eliminated, the couch has stood the test well, and one finds that it is now possible to give one's whole attention to the case under examination. A rather unlooked for and satisfactory feature is that Messrs. Cox & Co., who make this piece of apparatus (Fig. II.), can sell it for the same price, if

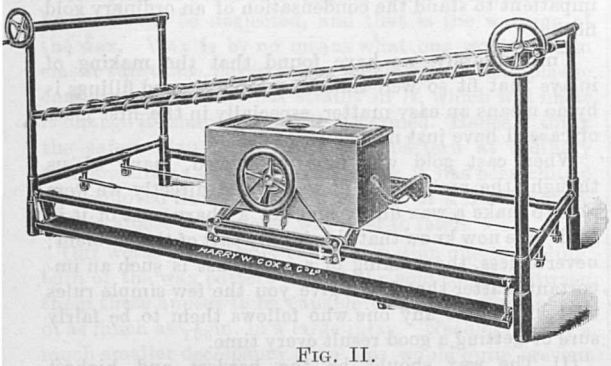

FIG. II.

not less, than several of the old-fashioned wooden couches now on the market which do not fulfil 25 per cent. of the functions of this metal variety. One should, perhaps, mention that one has no commercial interest in this matter.

The metal frame will, of course, pick up a little induced current. This is inevitable, but were we working on an ordinary wooden floor instead of cement this would not be apparent.

It has been suggested that the difficulties of induced current can be got over by "earthing" the metalled parts of a couch. A moment's reflection will show the fallacy. The current as supplied to the tube, a highly resistant body, is struggling for an easier path, and that to earth is easiest of all, the only obstacle being distance. If, therefore, you earth a piece of metal in the vicinity you break up this distance, and a continual stream of chattering sparks is the result whenever the resistance of the tube rises above a certain level. This is not all, for by earthing one high tension wire, you are earthing one side of your transformer, and thus increasing the already heavy strains on it. A breakdown of the most expensive part of your apparatus is then merely a matter of time. As an extra protection to the operator, a sheet of special X-ray opaque rubber is hung between operator and tube box, and a screen test shows the rays to be effectually stopped.

It is difficult to explain to those who do but little X-ray work the absolute necessity of foot control as compared with hand. A hand switch is an abomination, and the time and risk in attempting to find one in the dark makes the presence of an assistant imperative. But the assistant is really no substitute for a good foot switch, and no reliable modern apparatus is without this convenience. There are many points of similarity between the motor-car and an X-ray machine as regards control, and much may be learnt from a study of the evolution of the car. In the old days the driver had a multiplicity of levers, and thereby nominally had complete control. He altered the adjustment of his carburetter for each change of engine speed, etc. In the modern car, with less levers, the driver has more control. The means of effecting this difference is very simple, but the process by which it has been arrived at has been a long and difficult one—a process of trial and error.

So it has been with the X-ray couch. There is a certain school of radiography which maintains that all work should be photographic, and that a list of rules should be drawn up to decide exactly over what anatomical point the tube should be placed when a radiogram of a certain region is required—an attempt to reduce radiography to automatism. To such, a couch which enables a patient to be viewed from all points, meets with no favour. One is absolutely opposed to this school which relies for diagnosis entirely on a photograph taken by rules which regulate the exact position of tube in relation to the part being photographed. In other words, we are to confine ourselves to one or two views where we could have an indefinite number. There is but a very short step from this to the penny in the slot machine.

Change of Address.

Fleet-Surgeon Robley Browne, R.N., from Shotley Training Establishment to H.M.S. *Hyacinth*, Cape Station.

Oswald Marriott, M.D., from Hong Kong to the Manor House, Perry Hill, London, S.E. (from April to August whilst on leave).

A. P. Marsh, L.D.S., from 115, Mill Street, Kidderminster, to 43, Wellington Square, Hastings.

Dr. G. Bertram Muriel, from 109, Scotch Street, Whitehaven, to 80, Lowther Street, Whitehaven. Telephone No. 247.

Percy A. Peall, M.B., M.R.C.S., L.R.C.P., from Eldorado, Lomagundi, to Arcturus Mine, Enterprise District, near Salisbury, Rhodesia.

C. H. D. Ralph, M.R.C.S., L.R.C.P., from Cape Coast to Winnebah, Gold Coast.

Richard S. Roper, F.R.C.S., from S. Marylebone Infirmary, Notting Hill, to Jesselton, British North Borneo.

N. A. D. Sharp, M.R.C.S., L.R.C.P., from Guy's Hospital to c/o Colonial Secretary, Cape Coast, Gold Coast, W.A.

Geo. Steele-Perkins, M.D. His London address for the future is Arts Club, 40, Dover Street, W., in addition to the Country address given in GAZETTE of 1st February.

T. Bernice Tustian, L.D.S., to Jesmond House, 75, Walter Road, Swansea. *Telephone 271 Docks.*

Further Experience with Gold Inlays.

DENTAL LECTURE BY J. B. PARFITT.

GENTLEMEN,—I was lecturing on Gold Inlays not very long ago, but since that time a good deal of experience has been gained, and I thought it might be of interest to give a short account of present-day knowledge and practice in the subject. As I said then, I can still say, that I certainly think gold inlays have come to stay. Experience is, however, teaching us their proper use, and I think we now know pretty well the kind of case in which a gold inlay will give a more satisfactory result than any other method that is at all practicable. The good qualities of gold inlays are many and undoubted. Put briefly they are:—

(1) The great and unchanging strength of cast gold in the mass; I say nothing about its strength in thin sheets.

(2) Its great cleanliness under mouth conditions, due both to the high and permanent polish that can be given to it, and to the ease with which it can be contoured so as to give a proper shape to the inter-dental space.

(3) The comparative absence of tedious manipulation to the patient, with the important exception that in some, though not all, cases the cavity preparation is more difficult.

(4) Its permanence. In this connection I must draw your particular attention to the fact that you can only expect a gold inlay to be a permanent filling if its fit is what may reasonably be called perfect; to give a definite standard, so perfect that when it is finished it will be impossible to tell either by inspection or by feeling the edge with a sharp point, whether it is an inlay or a first class malleted cohesive filling. Unfortunately, we are much too apt to have one standard for one kind of tooth restoration, and another for another; especially crowns and inlays are sometimes allowed to pass with defects which would be universally condemned in an ordinary gold filling, and yet they are just as mischievous in the one case as the other.

A really perfect joint is, of course, impossible, the cement must always present an edge of some thickness, and it may very reasonably be argued that its solution must in any case be only a matter of time; practical experience, however, seems to show that a joint that is too fine to be visible, in some way (possibly by becoming filled up with debris) offers such an obstacle to solution that the inlay remains firmly set for a very long time indeed.

There are three classes of cases in which the special qualities of gold inlays make them useful.

(1) Large, so called "saddle-shaped" cavities, involving the mesial crown and distal aspects of molars and premolars; these teeth are often quite strong and one is loath to crown them; on the other hand, an ordinary cohesive gold filling would take so long to do properly that the patient could not reasonably be asked to endure it; amalgam, though most frequently used for these cases, is probably less suited for them than for any other kind of cavity, as the changes that are bound to take place in even the best amalgam are greatest, and have the most pernicious effects in the largest cavities.

(2) Large crown cavities in molars, especially lower ones.

(3) Medium sized cavities in people too nervous or too impatient to stand the condensation of an ordinary gold filling.

Unfortunately, we have found that the making of inlays that fit so well that they rank as good fillings is by no means an easy matter, especially in the first class of cases I have just mentioned.

When cast gold was first introduced, many of us thought the problem of fit was solved directly we were able to make a wax filling and get a sharp cast of it in gold. We now know that this is only part of the problem; nevertheless, the making of a good cast is such an important matter that I will give you the few simple rules that will enable any one who follows them to be fairly sure of getting a good result every time.

(1) The wax should be the hardest and highest melting that can be conveniently used in the mouth; it should be brittle rather than tough at the mouth temperature, and not of a very adhesive or "sticky" character.

(2) The wax pattern should be trimmed *absolutely* flush with the edges. In order to accomplish this, the softened wax should be introduced with some pressure, a matrix band being used in "three walled" cavities; the main part of the excess is most easily removed with hot instruments; the fine finishing of the surface and edge can best be done with *sharp* knives or chisels and sandpaper.

(3) The secret of uniform success in the actual casting is to work under uniform conditions, these are—

(*a*) Always use the same thickness of sprue wire.

(*b*) Always use the same investment.

(*c*) Invest the wax pattern at one invariable distance from the bottom of the casting ring, so that the air, which must of necessity escape from the hollow mould, always has the same thickness of investment floor to traverse, only thus will uniform casting pressure give uniform results.

(*d*) Heat the mould always to approximately the same temperature, and have the gold as hot as it can be got with an ordinary blowpipe.

(*e*) Always have the same casting pressure.

Each operator can soon find out for himself the best conditions for his own work, and when they have once been determined they should not be altered without some good reason. The great difficulty we have to contend with is the fact that inlays that are to all appearances perfect reproductions of the wax patterns, will in some cases not go quite home into the cavity, and in others fit too loosely; sometimes, again, they will fit without any apparent decrepancy. The only possible explanation of this imperfect fit is that the inlay differs

from the cavity in shape or size, or both. Any obvious excrescence due to careless investing or to cracking of the mould will, of course, cause misfit, and it has been stated that the interior of the mould may be damaged by the impact of the liquid gold. I think, however, that by careful use of good investment, and avoidance of overheating, all these possibilities may safely be neglected.

One possible cause of change of shape must, however, by no means be neglected, and that is the warping of the wax. Wax is by no means what one would call an elastic substance, nevertheless, moulding in a semi-plastic condition causes internal strains in it, which will make it change its shape directly it is warmed. Hence, I think the safest plan is to invest the pattern at ordinary temperature as soon as possible after it has been chilled and removed from the cavity, in spite of a disadvantage in this procedure which I will refer to later.

Our worse difficulty is the contraction due to cooling, both of the wax pattern and of the gold cast. Between them these appear to be capable of causing a shrinkage of as much as $\frac{1}{100}$in. in a large inlay. Needless to say a much smaller decrepancy than this would quite prevent a "saddle" shaped inlay from going into place, not to speak of the danger of having so much cement exposed to solution.

It must be pointed out that the importance of this contraction varies in different cases; where the joint is between two plane surfaces (the holdfast being obtained by means of a post) the contraction is of no consequence at all, the surfaces fitting one another accurately whether contraction takes place or not. Again, in cavities, the margins of which can be bevelled so that the opposite sides diverge from one another, the contraction is largely compensated for by the inlay seating itself a little deeper in the cavity; most molar cavities can be shaped in this way. In such cases the inlay should be made of 24-carat gold, and its fit made sure of, before cementation, by holding it firmly in the cavity and adapting the edge with a few blows of the automatic mallet.

Various ways of preventing the contraction have been proposed. One of the most ingenious of these is the plan of mixing the investment with water sufficiently hot to cause expansion of the wax pattern: the expansion of the wax can be so arranged as to neutralize the contraction of the gold. Perhaps the difficulty will be easily solved in some such way, but for the present I must confess to being afraid of the warping of the wax pattern in the hot water.

Another somewhat similar plan is to have the mould itself red hot at the time of casting, and so take advantage of the expansion of the investment caused by the high temperature. Another method is to cast on to a "stone" model. The crushing strength of the stone is supposed to be great enough to keep the gold from shrinking. I should strongly advise you to make a trial of this method as it is a very easy one and saves a good deal of manipulation to the patient, but I must confess that, so far, I have not found it overcome the difficulty of contraction.

A method of making inlays that I have been very pleased with is that of using the so-called "Alexander's plastic gold." As you know, this material is a kind of sponge gold impregnated with sufficient wax to make it readily mouldable. To make an inlay by this method the "plastic gold" is moulded into the cavity in much the same way as ordinary wax for casting. As the plastic gold is of a rather adhesive nature the cavity should be vaselined, or, better still, soaped, in order to facilitate the withdrawal of the pattern. As with a wax mould the plastic gold should be adapted, shaped, and trimmed with the utmost care. The investment should cover the cavity surface, the edges, and part of the remaining surface, the only part left bare being a patch in the middle of the free surface, amounting, perhaps, to about a third of its area, through which melted gold or solder is subsequently flowed into the interstices of the sponge to make it into a solid mass. No casting ring is used, and only a small quantity of investment is required, about an eighth of an inch thickness round and underneath the pattern being all that is necessary. When the investment has set, the mould is heated to dissipate the wax and then brought to a red heat; high carat solder is then made to flow into the gold sponge. When cool, the inlay only requires cleaning and grooving to be ready for cementing in the cavity. A little practice is required to avoid under-heating on the one hand, and over-heating on the other; one results in insufficient penetration of the sponge gold by the solder, and the other melts the whole inlay into a shapeless mass, or at the very least spoils the sharpness of the edge. Experience shows that inlays made by this method fit very well indeed; this is most likely due, partly to the fact that there is a solid framework of sponge gold which never gets melted at all, and partly to the high temperature of the mould at the moment when the solidification takes place.

Lastly, I would remind you that you can always make a gold inlay in the same way that a porcelain inlay is made, namely, by the use of a matrix of platinum, or even gold foil. In complicated cases, saddle-shaped cavities for instance, I think this is the easiest way of making a well fitting inlay; especially is this the case if we use what, for want of a better name, I call the method of the "re-inforced matrix." To make an inlay by this method a foil matrix must first be fitted to the cavity, or to a model of it: the foil may be platinum $\frac{1}{1000}$in. thick, or gold of the same stiffness. The matrix is then partly filled with gold by the ordinary pressure casting method; the gold core may be made of 24 carat, and should be of sufficient substance to prevent any distortion in the second casting; it should not extend quite to the edge of the cavity, about $\frac{1}{16}$in. of the foil margin being left free for the final fitting. Matrix and core are now transferred to the tooth cavity, and the foil margins thoroughly fitted to the enamel edge by careful burnishing. The matrix is now filled to contour with wax and cast a second time. This method is tedious but much less so than making a crown, which is occasionally the only satisfactory alternative to it; there is, moreover, the great advantage that in some cases it renders the devitalization of the tooth unnecessary.

London Bridge and the Borough in the Eighteenth Century.

(*Continued from page 46, new vol.*)

XVII.

BANKSIDE.

"Can this cockpit hold
The vasty fields of France? or may we cram
Within this wooden O the very casques
That did affright the air at Agincourt?"

King Henry V.

In all the talk that has recently appeared in the newspapers upon the subject of the proposed embankment of the Surrey shore, the erection of the new St. Paul's Bridge, and the forthcoming alterations to Southwark Bridge, scarcely a word has been said of the historic interest attaching to the ground which will be affected by all these changes.

Before the Tudor times Bankside was an ill-drained swamp, dark with trees and sparsely inhabited. The district which in 1671 was constituted the parish of Christchurch, now lying on either side of Blackfriars Bridge Road, was formerly the Manor of Paris Garden, so named from Robert de Paris in the reign of Henry II. "Paris Garden Stairs" still exist on the riverside to the east of the bridge, but Gerard would seek in vain to-day for "the hedge hog grasse, growing in watery ditches by Paris Garden bridge" which he found when collecting the material for his "Herball" of 1597. Originally the manor had belonged to the monks of Bermondsey, who sublet it to the Templars and to the Bishop of St. John of Jerusalem. Later, it was in the possession of John Duke of Bedford, and, after the Reformation, it became the property of Francis Langley.

From its situation beyond the limits of the City, it became, like other extra-mural districts, the resort of citizens in search of such amusements as were not permitted by the Lord Mayor within his domain. Bull- and bear-baiting, as at Hockley-in-the-Hole (Clerkenwell), Finsbury Fields, Tothill Fields (Westminster), and Moorfields, were to be found here. Bull-baiting of a sort, indeed, might have been enjoyed at any cattle-market. There was a bull-ring on St. Margaret's Hill in 1542, in the open street, where any likely young bull, destined for the meat-market on the western side of the Borough, was first expected to furnish some diversion to anyone who cared to risk his dogs.

On August 14th, 1666, Pepys went with his wife and Mercer to Bear Garden and "saw some good sport of the bulls tossing the dogs—one into the very boxes. But it is a very rude and nasty pleasure." Still the party was not depressed by the recollection, for that was the evening when they all played the fool with fireworks, "mighty merry, smutting one another with candle-grease and soot, till most of us were like devils," and Mercer danced a jig in "a suit of Tom's, like a boy" before they broke up between three and four in the morning.

There is little enough about Bear Gardens to-day to suggest its former attractions: but the old maps show the circus which was there in 1520, and the long range of kennels where some 120 mastiffs were kept. Some of the bears were known by name, and certain of them enjoyed a special celebrity; *George Stone*, *Harry Hunks*, and the bear about which Slender brags in "The Merry Wives of Windsor," *Sackerson*. This sport afterwards incurred official disfavour, and in 1665, Thomas Pride, then High Sheriff of Surrey, ordered the seven bears to be shot.

In Paris Garden and due south of Bridewell, was situated the earliest of the theatres on Bankside, "the Swan." Near by lived Henslowe, Alleyn, Cooke, Kemp, Lowin, Sly and other Elizabethan actors. The Falcon Draw-dock preserves the name of a celebrated tavern, the Falcon, with which all of them were familiar. Rendle discovered a reference (1598) to another local inn "the *Red Hart*, now called the *Olifant*," which he thought might well have been the much-discussed "*Elephant*" of "Twelfth Night," III., iij. Next came "the Rose" theatre, upon a site commemorated by Rose Alley, which for many years was held by Philip Henslowe. "Sweet as the Rose that grows by Bear Garden!" said Dekker, ironically. This is "the Playhouse" shown on Norden's map of 1593. Due south of Stew Lane Stairs was "the Hope" in Bear Gardens, where Ben Jonson's "Bartholomew Fair" was produced in 1614. In later years it came to be used for prizefights and in 1632 for bear-baiting, and finally was destroyed about 1666 to make room for tenements. Both the Rose and the Swan had a similar fate, and after 1620 were only used by gladiators and fencers.

Before the end of the sixteenth century the other theatres were joined by a fourth, the most famous of them all, the "Globe" playhouse. It was built in 1593, upon a site now included within the premises of Barclay and Perkin's brewery, of which one wall, facing on Park Street immediately east of Southwark Bridge, now bears a memorial tablet in low relief. The construction of Southwark Bridge in 1811 obliterated Globe Alley.

The Globe was taken over by Richard Burbage, the finest actor of his day, and son of James Burbage, who had been responsible for "*The Theatre*" and the "*Curtain*" in Shoreditch.

It was a wooden structure, hexagonal in shape externally, circular within, and the stage and galleries alone were protected by a roof thatched with reeds. Above the entrance a figure of Hercules (or Atlas) supporting the globe, with the motto *Totus mundus agit histrionem*, formed the sign. In 1603, James I., immediately upon his succession, granted a licence to Laurence Fletcher, William Shakespeare, Richard Burbage, Augustine Phillipes, John Hemmings, Henrie

Condell, William Sly, Robert Armyn, Richard Cowlye, and the rest of their associates, to act at "their now usuall house, called the Globe." The house was burnt down in 1613, but rebuilt in the year following.

"The Gull's Horn Book," 1609, by Thomas Dekker, gives some details of the interior of the theatre of the period. The "groundling" or "stinkard" paid one penny for admission to the open yard; by paying a supplement he might ascend thence to the "penny gallery" or the "two-penny room" and so on. Only a person of more importance would engage a seat in the "twelve-penny" or "Lord's roome" next the stage; although the value of this position had depreciated since gallants secured seats upon the stage itself. "By sitting on the stage, you have a sign'd patent to engrosse the whole commoditie of censure; may lawfully presume to be a Girder . . . . yet no man shall once offer to hinder you from obtaining the title of an insolent, overweening coxcombe," secure in the knowledge that you are not "to be hunted from thence, though the scarecrows in the yard hoot at you, hisse at you, spit at you; yea, throw durt even in your teeth."

Some fifteen years ago St. Saviour's put up a series of stained-glass windows, commemorative of the playwrights and actors associated with the neighbourhood; and within the past six months a recumbent effigy of William Shakespeare has been unveiled. Unfortunately the records of the old players are far too scanty to inform us to what extent the majority of them were acquainted with the inside of a church. In Shakespeare's case particularly it would be idle to follow his biographers in their surmises and conjectures; few of them venture upon assertions that are not qualified by "doubtless." He is said to have lived, at one time, within the Liberty of the Clink; Collier certainly forged a document to prove it. Condell and Hemminge, his friends and fellow-actors at Shoreditch and at the Globe, who edited the first folio in 1623, are buried at St. Mary's, Aldermanbury.

Aubrey tells us that Beaumont and Fletcher lived in the same house on Bankside near the Globe, "having all things in common, even sharing the same clothes between them." Fletcher was less fortunate in the matter of clothes after his partner was dead and buried in Westminster Abbey; for Aubrey, continues "the parish clerk, told me that he wash is (Fletcher's) taylor, and that Mr. Fletcher, staying for a suit of cloaths before he retired into the country, Death stopped his journey and baid him lie here." Fletcher died "in the great plague 1625," and was buried in St. Saviour's on the 29th of August. Philip Massinger died eleven years later, and, according to Sir Aston Cockayne, was buried in the same grave with Fletcher.

Of many other players, Burbage, Kemp, Sly, Lowin and "honest, gamesome Robert Armin, that tickles the spleen like a harmless vermin," very little record remains; other names find occasional mention in Henslowe's diary.

Philip Henslowe (buried in the chancel), originally a dyer and starch maker, became lessee of the rose theatre in 1584. From 1591, till his death, in 1616, he was in theatrical partnership with Edward Alleyn, who married his step daughter in 1592. He lived on Bankside "right over against the Clink" and owned the land known as Pike (or Pye) Gardens. In 1613 he was appointed sergeant of the King's bear-garden, to take charge of a lion and other animals presented by the Duke of Saboy. From 1593 to 1609 he kept a business diary in which various money-lending transactions are recorded, which is now preserved in Alleyn's College, at Dulwich. One of the earlier records is dated September 30th, 1594. "Received at Doctor Fostose . . . . iij li. xij s." Christopher Marlowe, the author of "Faustus," had been slain at Deptford the year before. Marston "the new poet," is mentioned in 1599. Among other items, at various times, Massinger, Field, and Daborne, collaborating on a play, ask for £5 on account. "Lent unto Francis Henslowe, to discharge himself out of the White Lion, £5." "To lend unto Harey Chettel to pay his charges in the Marshalsey, 30s." This is, perhaps, Chettle, the author, who in 1592 replied to the attack on Shakespeare in Greene's "Groatsworth of Wit," calling him *Shake-scene* and *Johannes Fac-totum*.

Ben Jonson was another of the authors who wrote for Henslowe. The latter, writing to Alleyn in 1598, says "I have lost one of my company that hurteth me greatly; that is Gabriel, for he is slain in Hogsden fields at the hands of Benjamin Jonson." The tragedy was the outcome of a duel at Hoxton between Jonson and Gabriel Spencer. "Rare Ben" narrowly escaped hanging; and was branded on the left thumb with a T, for Tyburn. His "Every Man in his Humour," was played at the Globe in the same year, with Shakespeare in one of the minor parts.

Edward Alleyn dwelt "hard by the Clynke by the banksyde near Winchester House." He was born on September 1st, 1566, and became one of the foremost actors of the day. Fuller says he "made any part, especially a majestical one, become him." Heywood called him "Proteus for shapes and Roscius for a tongue." He became a partner in Henslowe's business enterprises, and was finally sole proprietor of sundry play houses, and himself built the Fortune Theatre near Whitecross Street, St. Luke's. He first shared with Henslowe and afterwards succeeded him in the custody of the Bear Garden.

Having amassed a considerable fortune, Alleyn removed from the Clink to a Manor-house at Dulwich in 1607. Aubrey attributes the decision to found the College of God's Gift, to the sudden apparition of the Devil himself to Alleyn when he was performing as a demon in one of Shakespeare's plays. Whether or not this was the cause, by 1614 the building, from designs by Inigo Jones, was well under way. It was completed three years later, but difficulties arose in obtaining the Royal permission to settle the property in *mort-main*. Writing in 1618, Lord Chancellor Bacon had said, "I like

well that Alleyn playeth the last act of his life so well"; but, nevertheless, he put obstacles in the way when the application came before the King, who had refused Sir Henry Savile and Sir Edward Sandys when they would have endowed lectures at Oxford and Cambridge —"foundations" said the Chancellor, "of singular honour to his Majesty and of which there is great want, *whereas hospitals abound and beggars abound never a whit the less.*" However, the licence was signed on June 21st, 1619.

Alleyn still retained his interest in theatrical affairs down to the time of his death in 1626. Besides his College he founded Almshouses in Lamb Alley, Bishopsgate; in Bath Street, St. Luke's; and in Soap Yard, Southwark. He is said to have played parts in Lear, Othello, Romeo and Juliet, Pericles, and many other plays.

Among other property which had been Henslowe's but afterwards came into Alleyn's possession, were several of the former stewhouses, as well as the Unicorn, Bell, Barge and Cock inns. Another notorious inn of the neighbourhood was known as Holland's Leaguer, from which, possibly, Holland Street derives its name.

By 1648 all the theatres had been suppressed, and all of them had disappeared from Bankside before the Restoration. In their place the country was taken over by dyers, as numerous "tenter-grounds" (*Fr. teinture*) on the old maps testify.

In Zoar Street stood, in former times, a chapel in which John Bunyan used to preach.

There are persistent, though indefinite, traditions that Oliver Goldsmith once set up in medical practice upon Bankside. It is more than doubtful that he ever gained a qualification, although as we have seen the lack of one was no bar to practising in his time. He had commenced to study medicine at Edinburgh, but before long had left to spend some time at Leyden, whence he drifted across Europe as far as Padua, and on his return to England in 1756 he declared that he had obtained a medical degree at that University; but his own friends appear to have put little faith in the assertion. Although he contrived to obtain a medical appointment under the East India Company, for some reason or other it was very shortly afterwards revoked. On December 21st, 1758, he presented himself before the Court of Examiners at Surgeon's Hall, Old Bailey, to be examined for appointment as Surgeon's Mate in the Royal Navy. The position was secured by James Bernard, Oliver Goldsmith being "found not qualified for the same." If Tobias Smollet's account may be trusted, Roderick Random's knowledge, under precisely similar circumstances, was not put to any very exacting tests; though his friend John Jackson was not merely "ploughed," but committed to Bridewell by the Examiners!

When Goldsmith at length fell into the habit of saying, airily, "I do not practise; I make it a rule to prescribe only for my friends," Beauclerk retorted "Pray dear Doctor, alter your rule; and prescribe only for your enemies!" Perhaps the advice was accepted, for Goldsmith hastened his own death by insisting upon treating —ever his worst enemy—himself.

Hopton's Almshouses in Holland Street were already established before Blackfriars Bridge was built in 1769. In Albion Place, where the roadway widens on reaching the Surrey shore, was, from 1788 to 1806, the Rotunda, containing the Lever Museum, which included many of the objects of interest brought home by Captain Cook. At the White Horse "in Old Gravel Lane, near Hughes's late riding school," was a cock-pit, well known in the late eighteenth and early nineteenth centuries.

The Surrey Chapel, at the corner of Charlotte Street, Blackfriars Bridge Road, has fallen from its former estate and become a cinema theatre and boxing-ring. It was built in 1783 in hexagonal shape. The Rev. Rowland Hill, who occupied the pulpit, said he liked a round building where there were no corners for the devil to hide in.

It was in Charlotte Street that a gang of quacks established themselves about 1813, widely advertising that the concern was under the control of Dr. *Ashley* Cooper. Many patients were swindled out of large fees under the impression that they had been seen by the fashionable surgeon, Mr. Astley Cooper.

Mention has already been made of the "Halfpenny Hatch," near Christchurch. The name of William Curtis, the quondam assistant of Dr. Fordyce, of St. Thomas's, was associated with this footway which ran through the botanical gardens, to which he removed on leaving Grange Road, after 1771. He subsequently moved to a still larger establishment in Brompton.

(*To be concluded.*)

Appointments.

Royal Navy

Fleet-Surgeon Robley H. G. Browne has been appointed to *Hyacinth*, Cape Station, dated 28th January, 1913.

Staff-Surgeon W. P. Walker has been appointed to *Carnarvon*, additional for second and third Fleets.

Surgeon H. M. Langdale has been appointed to *Victory*, additional for disposal.

I.M.S.

Captain H. Stott, M.B., B.S., has been nominated Surgeon to His Excellency the Governor of Madras.

Territorial Force.

Fourth London General Hospital, Edmund Spriggs, M.D., F.R.C.P., to be Captain whose services will be available on mobilization.

Civil.

E. P. Hudson, L.D.S. Eng., to be Dental Surgeon to S. Marylebone Home for Incurables.

T. Bernice Tustian, L.D.S., has been appointed a Dental Officer to County Borough of Swansea Education Authority.

The Misuse of Enemata.

A NOTE BY Mr. CHARTERS SYMONDS.

It is customary to administer enemata as if no harm could result. There are conditions where not only are they harmful, but even dangerous. I would raise the question whether an enema is of much value at all in diagnosis.

The mere mechanical effect in healthy persons may give rise to discomfort, even shock. It is with some surgeons and many nurses still the custom to give an enema before any operation; for example, an hour before an abdominal section (or a large breast operation). This I have seen followed by vomiting and cardiac distress. The disturbance comes at a time when the greatest repose possible is required. For many years I have recognised the evil of the practice, and abandoned it, but still find it necessary to give directions as to its omission. An enema in some people causes pain not only because the nozzle becomes caught in the anal folds, but also on account of the distension of the bowel. Before some rectal operations perhaps the practice may be defended, but even here I believe it to be wiser to defer the irrigation till the patient is under the anæsthetic.

In acute abdominal conditions almost the first thing one is told is that a nurse has been sent in to give an enema, as if this practice were fraught with some valuable influence. That this practice is advocated and taught by many has come before me when I have asked why there was so much delay in bringing an acute appendix into the theatre. The answer is, the House-Surgeon had ordered an enema.

What harm does a rectum loaded with fæces do when the material is formed and dry? In these acute conditions there may be positive danger, as in the following example: A young lady of 19 had acute abdominal symptoms, thought to be due to inflammation of the appendix. The enema ordered by the medical attendant caused in the giving of it much pain, but was, nevertheless, persisted in. There followed intense pain and vomiting, and all the signs of rupture of an abscess. This I confirmed when the abdomen was opened six hours later. The abscess was pelvic; no rectal examination had been made. The patient recovered after a fourteen hours' battle with vomiting. A nurse failing to give an enema because of the pain experienced would naturally fear being charged with want of dexterity, and persists against even her better judgment. The whole view is based upon the conviction that an enema is harmless. When I am told on arrival at an acute case that an enema has been administered and told with some satisfaction, I mentally hope that no harm has resulted. I admit that harm rarely follows, and if the rectum be previously examined by the medical attendant there is not much risk of an abscess being ruptured, but there does remain the general upset to a patient—a nervous patient—who has never had such a thing.

Finally, it is unnecessary, and so far as I can see in acute conditions gives no information. It is better dispensed with. One sees the evil of the practice, more especially in children, who are often frightened and distressed, and by their struggles definite harm may follow. It cannot be wise to force in fluid against powerful efforts at expulsion.

After operations, especially for acute appendicitis, much anxiety is caused, and quite unnecessarily, by the sluggishness of the intestine. Mild aperients fail; a strong variety is, perhaps, undesirable, and resort is had to enemata. It must be recognised that after abdominal operations a certain degree of paralysis of the bowel results, just as happens from a severe blow. The greater the interference, as, for example, in a resection, and more particularly in septic cases, the more prolonged will be the effect. The best treatment is patience, and almost invariably within the fourth day the bowels act, or, at any rate, the distension will pass away. Enemata in this stage in my experience are distinctly harmful, and even dangerous. The irritation increases secretion above the block and aggravates the symptoms. In children I have twice known the bowel ruptured. I had removed a gangrenous appendix with an abscess in a boy of five. His progress for just a week was all that could be desired, and I felt justified in leaving town. Grey powder failing to act, he was given enemata, and after one of these he had abdominal pain and vomiting. A swelling formed to the left of the median line, and had to be opened by another surgeon, when some fluid was evacuated. Now this boy was quite well and did not require a purgative at all. In another instance soapsuds were washed out of the abdominal cavity. Here, again, recovery followed.

It may be urged that there was rough handling on the part of the nurses. Rather are such

results to be attributed, in the first place, to the condition of the bowel, and, in the second, to the resistance of the child. In all acute appendicitis the pelvis is more or less filled with serum, in many with pus, and coils of ileum occupy this region. The rectal wall or that of the folded pelvic colon may well be softened and adherent and liable to injury. The expulsive efforts of a child must throw greater strain on the intestine. Again, I cannot believe that these enemata are required. In chronic obstruction, perhaps, one sees the greatest evil from enemata, whether it be in the large or small bowel. When aperients fail, the enemata are increased in amount and in frequency, and are given by a long tube, and to be sure that all has been done the medical attendant does it himself.

This is a summary of the methods I see adopted to-day. I am not finding fault at all with those who practise these orthodox methods; I want to raise the question as to the wisdom and value of the proceeding.

Let us take a typical stricture of the colon—the usual malignant variety. Where there is visible coiling without sickness, and without relief to the bowels, I fear in such conditions the habit of giving aperients is still far too prevalent. Most patients have at least one dose of castor oil, often fortunately rejected, and generally calomel in small doses, followed by white mixture. Interspersed with these are enemata, and when aperients have been abandoned the enemata are pushed. This is by no means an exaggerated account of the usual practice; it is a simple statement of what has come before me in several cases recently.

I cannot here go into the treatment of chronic obstruction, but I would just like to say that all aperients are evil. Before medical aid has been called the patient has employed more than one variety, and the time has come for rest. The obstruction is more likely to yield under small doses of belladonna and opium than under any purgative, a result not difficult of explanation when one contemplates the morbid anatomy of the condition. The object in giving the enema is, I take it, to inject the material above the obstruction. A moment's reflection will show that this would increase the distension, the pressure on the growth, and magnify the very conditions deterring the obstruction. Fortunately the fluid very rarely, if ever, except where a catheter is passed through a rectal stricture passes above the obstruction. What good can it effect if it do not? It can act by "irritation" only, and this leads to increase of secretion above the obstruction, greater distress, and hurries on that œdema of the bowel, soon to be followed by absorption of toxic products and peritoneal infection.

The justification in the minds of those employing enemata in these cases is the occasional relief that ensues. I would go so far as to say that the relief comes in spite of the remedy. In proof whereof one could cite cases where relief has followed, and I believe more often followed, avoidance of all irritation, assisted by small doses of belladonna and opium. Consider for a moment how long a patient may remain without an evacuation, and with complete obstruction. Two or three weeks was a common period in the days when operation was not performed till the last moment. When acting as operating surgeon in Hilton Fagge's wards in the early eighties such cases were common. My first colotomy—a left lumbar—was performed on a man of 70 obstructed 21 days, and he survived. The most remarkable instance that has come to my knowledge I operated upon last year (1912). A lady of strong physical power had had complete obstruction for nine weeks, and was quite comfortable. The abdomen was enormous, the coilings visible and vigorous. She was alert in mind and cheerful. On two occasions only had there been sickness, once in the early stages when she had aperients, and in the third week when a surgeon called in to see her, looked upon the condition as neurotic, and ordered croton oil. After this no aperient had been employed, though enemata were continued. She lived on water, a little beef juice, and a couple of ounces of brandy. Drainage of the sigmoid, and after three weeks resection of the bowel lower down were safely carried out. Can any case prove more clearly what the bowel can endure if kept quiet? And, conversely, demonstrate that the greater troubles and the increase of symptoms are due to our treatment, in our anxiety to obtain a passage? It must be obvious that the intestine is in a far worse condition for handling when irritated by purgatives and enemata, and the patient is in a far less suitable state to bear operation.

In the light of such a case as I have mentioned we must review our methods of treatment, and where early operation is not contemplated, revert to the older and safer plan of resting the obstructed bowel. Purgatives and enemata hurry on the toxic effects, a result

easy of explanation. I saw last year an elderly lady so ill with toxic absorption after four days' active treatment that it was not thought she could survive a colostomy. This patient had been walking about just before with moderate symptoms only. She, however, with a little management survived not only colostomy, but resection later on.

One quite appreciates the mental attitude at the present day of the physician who is dealing with a chronic obstruction. He feels that he must try aperients and enemata before resorting to operation, in case there may be a fæcal impaction. There can be no other cause, and one cannot but ask, is impaction ever met with? I mean sufficient to cause visible peristalsis and hypertrophy of the bowel. It has certainly never come my way in over thirty years' operating.

It is in these cases of stricture of the colon that the long tube is employed. I well remember when it first came into use, and have heard Fagge upon its value. It has not fulfilled expectations, and though still employed does, I believe, more harm than good, for if it pass through the stricture—a most unlikely feat—the fluid injected is more likely to determine rupture of the cæcum than evacuation of the contents. The insertion of two feet of elastic tube is no proof that the end is up to that height in the bowel, for it may have turned back, and frequently does so.

In these cases where the stricture is in the pelvic colon (sigmoid), it is remarkable how much fluid can be introduced. Two and three pints are easily held. One has more than once accepted this as a sign that the stricture was high up, to find it after all in the sigmoid.

The worker with enemata in chronic stricture of the colon will present you with small fæcal balls as a result of one or more heroic efforts. These are formed below the obstruction from fluid that has oozed through the lumen. The water is absorbed, and the solid material is rolled into balls by the peristaltic movements. The material above an obstruction is fluid, or pultaceous, and the greater the amount of irritation, and so of secretion, the more fluid will be the contents.

In criticising the use of enemata and aperients in these stricture cases, one does not overlook two advantages. It is well known that spontaneous relief may follow, and more than once in this type of case. It has occurred after light manipulation, and it was this that led Jonathan Hutchinson to suggest inversion, for relief may be due to the accidental change in the position of the distended bowel. I have seen an obstruction completed by the folding over of the distended bowel just above a stricture sufficiently patent to permit the passage of the fluid material as soon as the bowel was replaced. Some such change may be brought about by increasing the peristalsis, but it is more likely to occur by relieving the overaction. I have seen in the early days aspiration of a distended cæcum, followed by complete recovery. It was a dangerous practice, but was then less so than abdominal section. It demonstrated, however, the effect of relieving overdistension.

A second advantage is the absorption of water when the enema is retained. But those who desire an aperient effect look upon retention as undesirable, and repeat the injection to remove that which has been retained.

Saline enemata given with a view to absorption are good, and this result is promoted by avoiding peristalsis.

The overuse of enemata will give rise to hypersecretion of mucus, and I have been called to such a case as one of colitis. The patient, a lady, had some right iliac pain and tenderness of the ascending colon. Later, a lump was observed in the cæcal region. This was thought to be impacted fæces, for which enemata were given daily. These were followed by much mucus passed between the administrations, and occasionally the mucus was blood stained. The case was one of mild appendicitis, the mucus disappearing as soon as the enemata were discontinued, and the lady recovered. I believe this result of enemata to be no uncommon sequel, especially if associated with the use of such aperients as cascara.

Pass List.

Royal College of Physicians of London.

At a Comitia held on Thursday, 30th January, the following having passed the required examination, was admitted Member of the College.—N. Mutch, M.B., L.R.C.P.

The Diploma in Public Health was granted to P. Rose, L.R.C.P., M.R.C.S. (in conjunction with the Royal College of Surgeons).

The following were elected Councillors:—Sir E. Cooper Perry, M.D., F.R.C.P., E. H. Starling, M.D., F.R.C.P.

The Methodical Examination of the Eye.

By Mr. WILLIAM ANDERSON.

WHEN teaching in the Eye wards, the writer frequently observed that many, when beginning to study diseases of the eye, examined the organ without method, often neglecting to make a complete examination. Thus important facts are missed, and the diagnosis made may be wrong, whereas if the following order were observed such errors would be avoided.

Before examining the eyes, however, it is well to make a note of the general aspect of the patient, as this may suggest a particular line of inquiry. Does he walk in an unusual way? His vision may be much reduced, or he may have tabes with ocular symptoms. Has he torticolis? This may be due to paralysis of some ocular muscles or to strabismus. Does he tilt his head backwards, owing to "ptosis"? He may have trachoma or myasthenia gravis. One may read much in the patient's face; the aspect of exophthalmic goitre, and that of facial paralysis are well known. The screwing-up of the eye-lids in photophobia suggests some disease of the cornea or iris, and a puffiness of the lids is one indication of kidney disease.

The objective examination of the eye should be done in a definite order, superficial structures before deep or the structures in order from before backwards. Both eyes should be examined, first the particular structure in the right eye, then the same structure in the left. By doing so, a more convenient comparison between the conditions of the two eyes can be made than if one eye is first completely examined. The patient should be placed in a good light. Sir George Humphry's rule, "Eyes first and much, hands next and little, tongue not at all," is peculiarly applicable to the examination of the eye, for practically all the parts can be seen.

Examine in the following order:—

1. LIDS.—*a. Position.*—Is it normal? Abnormal: inversion, eversion, ptylosis or drooping of the lid due to chronic inflammation or trachoma.

b. Lashes.—Are they correctly placed? No; in trichiasis the lashes are directed backwards on to the cornea. A double row of lashes is called distichiasis.

c. Movements.—Note their power of opening and closing, and the breath of the palpebral fissure. Abnormal: in ptosis, facial paralysis and myasthenia gravis.

d. Glands.—(i.) Meibomian.—A condition of the meibomian glands, which is not widely recognised, is a chronic condition caused by staphylococci or other organisms, and having symptoms similar to conjunctivitis. To examine the glands, the conjunctiva should be cocainised, then the lids squeezed between the nails of the thumbs and the contents of the glands and their ducts expressed. If a "cheesey" like substance exudes, it may be examined bacteriologically. Though the procedure is unpleasant to the patient, the results obtained by its repetition amply justify it, and it is worth remembering. Look also for meibomian cysts.

(ii.) Zeiss's glands.—Inflammation of these occur in blepharitis and stys.

2. THE LACHRYMAL APPARATUS.—*Puneta.*—It should be noted whether the puneta are in apposition with the globe and dipping properly into the locus lachrymalis.

Lachrymal sac.—Unless acute inflammation is present, whether there is a swelling or not, pressure with the index finger should be applied over the region of the sac. It is of particular importance to do this when an operation involving the opening of the eyeball is contemplated.

3. THE GLOBE.—*Size.*—Is the size equal on both sides? Abnormal: buphthalmus, microphthalmus.

Position.—Do they protrude? (proptosis, exophthalmus.) Do they recede? (enophthalmus.) Is there strabismus? The amount of squint should be measured.

Movements.—Are they good or defective?

4.—CONJUNCTIVA.—Both the ocular and palpebral conjunctiva should be examined. The former is readily seen. To examine the latter the lower lid is drawn down and then the upper is everted. The eversion of the upper lid requires some skill, which is obtained by practice. Stand in front of the patient, use the left hand for the patient's right eye and the right for his left eye. Direct the patient to look at you, place the thumb on his lower lid, direct the patient to look down, as he looks down push the lower lid backwards and a little upwards, the upper lid comes in front of the thumb, now place the index finger along the upper lid, which is everted by a rolling movement of the thumb and index finger. It is important to examine the conjunctiva of the upper lid.

5. CORNEA.—The cornea should be clear and have a bright surface reflex. Note if there are any opacities and whether they are superficial or deep. Is the reflex regular? If uncertain whether there is a surface abrasion or not, instil fluorescene drops; abraded surfaces are stained green.

The cornea is best examined in a dark room by concentrating the rays of a lamp on it with a + 15 D. lens. Only by this method are some opacities seen in the cornea. The use of a binocular loupe is of great advantage in ascertaining the depth of opacities.

The sensitiveness of the cornea is tested by applying a fine thread of cotton wool.

6. SCLERA.—If the sclera is thinned and staphylomatous, the pigment of the subjacent choroid is seen shining through.

7. THE ANTERIOR CHAMBER.—Note its depth and whether the aqueous humour is clear. Inflammatory exudate, pus, and blood gravitate to the lowest part of the chamber.

8. IRIS AND PUPIL.—Observe its colour and whether its fine tracery of markings is distinct. Note the plane of its surface, and whether it is immobile during movements of the eyeball.

Examine the pupils as to their relative size, shape, and position. Determine their reaction to light, both

directly and consensually, noting their maintenance of contraction. Test the reaction of the pupil to convergence and accommodation. To recognise adhesions between the iris and capsule of the lens, it is sometimes necessary to instil atropine or homatropine drops.

9. THE LENS.—The lens should always be examined in a dark room by the ophthalmoscope—the neglect of this method may lead to grave error, for the greenish-grey pupillary reflex of glaucoma otherwise may be mistaken for cataract. In addition, focal illumination may be used. To examine the lens thoroughly a mydriatic should be instilled.

Before using a mydriatic the tension of the eye, especially in elderly patients, should be taken.

10. TENSION.—To estimate the intra-ocular tension, the patient is directed to look down, the tips of both index fingers are placed on the upper lid and pressed downwards alternately on the globe. The tension of one eye is compared with that of the other. By practising on normal eyes the student should obtain an appreciation of what is the normal tension, thus he will recognise when the tension is raised and when lowered. Experience will teach him to estimate the amount of increase. Though tonometers may be more scientifically accurate, the student should not neglect the above method.

11. VITREOUS. - The vitreous normally is clear. Look for exudates, hæmorrhages, and floating opacities.

12. FUNDUS (RETINA AND CHOROID)—The vitreous and fundus are examined by means of the ophthalmoscope. There are two methods of using this instrument, the indirect and the direct, both of which should be practised; the indirect first, because a larger field and a more luminous image are seen (it should be remembered that the image is inverted), and so a general aspect of the fundus is obtained; then the direct, which gives a highly magnified erect image so that the finer details may be examined.

The examination is done in a darkened room. The surgeon sits opposite the patient, a little behind whose head a lamp is placed, on the same side as the eye to be examined.

In the indirect method, a convex lens of fourteen dioptres is held about two and a half inches from the patient's eye. Rotate the lens, which will correct the observer's vision for about fourteen inches reading distance, behind the ophthalmoscope; place the instrument close to the right eye.

The retina should be examined systematically, beginning with the optic disc; this is readily seen in the patient's right eye by the surgeon's directing him to look at the tip of the surgeon's right extended little finger, and in his left eye by his looking towards the tip of the lobule of the surgeon's left ear. The macula lutea, the most important part of the retina for vision, lies one and a half to two optic-discs' breadths outward from the outer margin of the disc.

The retinal vessels should be traced from the optic disc to the periphery—a venous pulse is physiological, an arterial pulse pathological.

In a healthy state the retina is transparent, and behind it the choroid, with its circulating blood, presents a red background. The individual choroidal vessels are not usually seen owing to the pigment epithelium. But when the pigment is more profuse between the vessels, these are seen bright red; such a fundus is called "tessellated," and the appearance must not be mistaken for choroiditis. Also, when the pigment is scanty, especially in albinos, the whole network of choroidal vessels may be seen.

In the direct method, the small obliquely-placed mirror of the ophthalmoscope is used; it is rotated into the position which throws the light into the patient's eye. The surgeon sits close to the patient, in front of him and on the same side as the eye to be examined. Holding the mirror close to his eye (the right for the patient's right, and the left for the left), he leans forward until the mirror is about three-quarters of an inch from the patient's eye.

By altering his point of view, or by directing the patient to rotate the eye, the fundus, especially in hypermetropes, can be seen nearly to the ora serrata; in myopes this is not possible.

13. VISION.—Acuity of vision is expressed as a fraction—

Distance of patient from the test type.
Distance at which patient should see the type.

The patient is seated six metres distant from the type. Test each eye separately.

If he can read the line, which should be seen at six metres, his vision $= \frac{6}{6}$; if the line at 18 metres, his vision $= \frac{6}{18}$, and so on. If his vision is less than $\frac{6}{60}$, he should be seated nearer the type; if it is less than $\frac{1}{60}$, test in the following order:—

(1) Counting fingers, noting the distance the fingers are held from the eye.

(2) Hand movements.

(3) Shadows.

(4) Perception of light. If he has no perception of light, the eye is blind.

The near vision is tested, each eye separately, by Jaeger test-type, noting the size of type read and the distance from the eye at which it is held.

14. FIELD OF VISION.—This is an examination of the limits of indirect vision. Each eye is examined separately. The eye examined is directed at a fixed point, the other eye is covered up. The simplest way is by using the hand as a test object, the surgeon being directly in front of the patient and near to him.

The patient is directed to look with his right eye at the surgeon's left, the left eye of the patient is covered; the surgeon's right eye is closed, his left looking at the patient's right. The surgeon gradually moves his hand from the periphery inwards, the patient says when he sees the hand. The surgeon sees the hand also, and if his and the patient's fields are normal, they should both see the hand at the same time.

A more accurate and graphic record of the field is obtained with a perimeter and chart. The arm of the

perimeter is moved through the degrees of a circle; at varying intervals, for example, every thirty degrees, the arm is stopped and along it a test object is moved from the periphery inwards. The test object is usually a 10–15 m.m. square of white, for "colour-fields" the particular colour is used. The eye under examination is directed to the fixation point of the instrument, the patient signals when he sees the test object and this point is recorded on the chart.

Pathological alterations of the field are its contraction from the periphery inwards; the loss of a half, nasal or temporal, upper or lower; the loss of a part, the area of blindness being called a scotoma. The latter is recorded by moving the test object along the arm of the perimeter from the periphery to the centre and recording on the chart the point where the test object is lost to the patient's vision and the point where it becomes apparent again.

15. REFRACTION.—This requires special consideration.

A Case of Simultaneous Inoculation of Syphilis in Two Remote Regions.

BY C. H. MILLS.

THE accompanying photograph is that of a man (æt 43) who six weeks previously was exposed to infection with syphilis. After an incubation period of exactly 18 days patient first noticed a small sore on the frenum.

and also a "pimple" which had previously healed, reappeared on the right side of the tip of his nose. In each instance the lesion slowly and painlessly increased in size, until that on the nose attained the size of a sixpenny-piece in a little over a fortnight (17 days) after its commencement. At this stage I first saw the patient —exactly five weeks after infection. He then exhibited a typical Hunterian chancre at his frenum, with the epithelium intact over its surface, with an underlying cup-shaped mass of induration standing out like a piece of pearl-coloured cartilage. There was marked painless inguinal adenitis and a thickening of the dorsal lymphatics of the penis. The sore on the nose was strikingly indurated and circular, the edges being raised and somewhat rolled. The base was covered with a dry, black scab. In appearance the lesion much resembled a malignant pustule of the same size, except for the absence of the surrounding area of "angry" looking infiltration. The lymphatic glands in the sub-maxillary region on the left side (the opposite side to the sore on the nose) were greatly enlarged as is well shown in the photograph, and painless. He was smothered in a papulo-squamous rash, becoming pustular on the extremities. The fauces were very infected but not definitely ulcerated. The teeth in good condition. The cords thickened and hyperæmic. Voice husky. Spleen palpable (numerous anal mucous patches). Slides prepared from nasal chancre exhibited an abundance of S. Pallida. The frenal chancre was too "healed-over" to render slides practicable.

The chief points of interest in the case are: (1) The simultaneous (and of course only possible as such) inoculation at two sites so remote; it being fairly common to find two or more infected foci grouped in one region. The explanation given by the patient that he "burst a pimple" on the exact same spot at the time of inoculation and so infected himself, seems quite feasible.

(2) The rapidity and severity of the general infection. We are entirely dependent upon the patient's statements, of course, as to the accuracy of his dates, but in this instance they should be reliable—at any rate that of the inoculation—since it occurred on last Christmas Eve, previous to which he had not been exposed to infection for some months.

I am indebted to Mr Todd for the time and trouble he took to procure the photograph on one of London's foggy mornings.

Albert Kahn Travelling Fellowships.

Attention should be drawn to the Albert Kahn Travelling Fellowships, two of which, each of the value of £660, are awarded annually. The candidates must be British subjects, graduates of some University in the United Kingdom, and preferably men between twenty-five and thirty years of age.

The purpose of the Fellowships is to enable the persons elected to travel round the world, and thus broaden their outlook and sympathies.

The Vice-Chancellor of the University of London has been requested to exercise the right of nominating a candidate.

Further details can be obtained from the Dean, but applications must be sent in before the 26th February.

Summary of Anæsthetics and Operations at Guy's Hospital for the Year 1912.

The number of cases in which general anæsthetics were administered was 7,031, among which were 28 intravenous injections of ether, five of hedonal, and 25 intratracheal insufflations of ether. Spinal anæsthesia was also employed on 16 occasions. Of the 7,047 administrations, 214 were for the purpose of examination, 121 for dressings, and 60 for the extraction of teeth, while in two cases three operations were performed under one anæsthetic; in one hundred cases two operations were performed under one anæsthetic; in four cases an operation and an extraction; in two cases an operation and a dressing; in thirty cases an operation and an examination; and in two cases an examination and a dressing. The total number of operations, therefore, was 6,790 in Wards (Bright Ward excepted), Special Departments, Out-Patient Departments, and Surgeries. There was no case of death from anæsthetic, but two cases of death during anæsthesia were reported to the Coroner, particulars of which are furnished in the Appendix.

Operations done on the medical side are entered under the assistant surgeons corresponding to the physicians or assistant physicians in charge of the wards, the Table below showing how many operations are actually performed in these wards.

There have been 5,617 cases of general anæsthesia in the Dental department; 5,208 under nitrous oxide gas, 378 under ethyl chloride, 15 under gas and oxygen, and 16 under ether.

Anæsthetics.

A.C.E.	1,126
Chloroform	716
Ether (including gas and ether)	1,073
C.E.	1,943
Gas	757
Other anæsthetics, mixtures and sequences	1,358
Spinal anæsthesia	16
Intravenous ether	28
Intravenous hedonal	5
Intratracheal insufflation of ether	25
	7,047

Administration of Anæsthetics.

Administrator.	No. of Cases.
Staff Anæsthetists	1,601
Visiting Staff	592
Resident Surgical Officer	39
House Officers	3,692
Clinical Assistants	641
Other Qualified Men	482
	7,047

Operations.—Tabulated According to Wards and Departments.

Astley Cooper	378	Mary	36
Cornelius	322	Stephen	30
Lazarus	316	Esther	36
Job	506	Queen Victoria	441
Naaman	273	Clinical	82
Luke	314	Isolation	11
Patience & Samaritan	275	Out-Patients'	1401
Charity	355	Front Surgery	267
Dorcas	339	Back Surgery	25
Lydia	324	Light Department	4
Martha	277		6790
Eye Wards	753		
Addison	25		

Turning to the general wards, it may be noted that the totals of operations are as follows:—

Surgeons	949
Assistant Surgeons	906
Specialists	21
Resident Surgical Officer	260
House-Surgeons and Assistant House-Surgeons	634
Surgeons' Dressers and Assistant Surgeons' Dressers	791

The remaining 13 operations, bringing the total up to 3,574, were performed by other operators.

It should, of course, be remembered that all operations in wards by Dressers and Resident Staff are performed under the supervision of the Resident Surgical Officer or of the Surgeon in Charge, and that no account is taken of operations done either under local anæsthetics or without anæsthetics at all.

Operations in the Obstetric Department (Queen Victoria and Patience Wards) number 467, of which 124 were performed under supervision by the Obstetric Residents, 37 by the Obstetric Dressers, 90 by the Obstetric Assistant, 212 by the Obstetric Surgeons, and two by other operators.

The operations upon Ophthalmic cases in the wards number 218, of which 35 were done under supervision by Ophthalmic Dressers, 25 by the Ophthalmic House-Surgeon, 20 by the Ophthalmic Assistants, 6 by Mr. Higgens, 124 by the Ophthalmic Surgeons, and 8 by other operators.

There were 723 operations upon Throat and Ear cases in the Wards, 322 by the Surgeons themselves, 86 by the Clinical Assistants, 32 by the Ophthalmic House-Surgeon, 281 by Dressers, and 2 by other operators.

In the Orthopædic Department 47 operations were performed, 17 by Mr. Rowlands, 1 by Mr. Trethowan, 2 by the Resident Surgical Officer, 9 by the House-Surgeon, and 18 by Dressers.

In the Genito-Urinary Department 86 operations were performed, 43 by the Surgeon himself, 6 by the Resident Surgical Officer, 1 by the House-Surgeon, and 36 by Dressers.

The Operations in General Out-Patients number 461, nearly all of which were performed by Dressers under the supervision of the Assistant House-Surgeon or the Surgeon.

In the Front and Back Surgeries 292 operations were performed, 1 by an Assistant Surgeon, 8 by the Resident Surgical Officer, 59 by Out-Patient Officers or House-Surgeons, and the remainder by Dressers.

In the Special Out-Patient Departments, 13 operations were performed upon Eye cases, 4 by the Surgeons, 1 by an Ophthalmic Assistant, 1 by a Qualified Clinical Assistant, and 7 by Dressers; 3 in the Obstetric Department, 2 by the Obstetric Assistant, and 1 by a Dresser; 827 upon Diseases of the Throat and Ear, 5 by Surgeons, 65 by Qualified Clinical Assistants, 2 by the Ophthalmic House-Surgeon, and 755 by Dressers; 38 in the Orthopædic Department, 1 by the Surgeon himself, 15 by Mr. Trethowan, 1 by Mr. Todd, 14 by Qualified Clinical Assistants, and 7 by Dressers; 36 in the Genito-Urinary Department, 4 by Qualified Clinical Assistants, and 32 by Dressers; 4 by Dr. Iredell in the Light Department, and 1 by Dr. Cameron in the Children's Department.

The Anæsthetics given in the Dental Department were 5,617, Gas, 5,208; Ethyl Chloride, 378; Gas and Oxygen, 15; and Ether, 16.

APPENDIX.

1. *Death after attempted removal of a cervical gland*, June 17th, 1912.—Ethel Roberts, æt. 35, was admitted on June 8th, 1912, under Dr. Pitt, in Esther ward, for glandular enlargements. A cervical gland was being removed for purpose of diagnosis, under the supervision of the House Physician. Some hæmorrhage occurred, which was arrested by means of pressure forceps, and these were left in place for about three hours. The Resident Surgical Officer was asked to supervise the vessels being ligatured. Immediately the forceps were removed there was a big gush of blood, which was partially controlled by pressure. Since the woman was very frightened, the R.S.O. asked the House-Physician to just make her unconscious with an anæsthetic. This was done, only very little being used.

The hæmorrhage was practically uncontrollable, and a good deal of air was sucked into the veins. The woman collapsed, and died about a quarter of an hour after the anæsthetic had been stopped.

At the autopsy made by Dr. Spilsbury it was found to be a case of very advanced Hodgkin's disease. A laceration about half an inch across was found at the junction of the internal jugular and subclavian veins on the right side, the glands being adherent to those veins.

2. *Death under early anæsthetic before the beginning of operation.*—Frederick Pieri, æt. 31, was admitted to Astley Cooper, 12, under the care of Mr. Thompson, on August 10th, 1912. He was suffering from general genito-urinary tuberculosis, for which several operations had been performed. His condition, however, became more and more serious, until at last it was decided that the only hope of saving his life lay in the performance of suprapubic cystotomy for drainage purposes. It was recognised that this must of necessity be a very dangerous proceeding; but it was felt that, as a last resort, the operation was justifiable, and it was undertaken on September 20th, 1912. Dr. Lancaster gave the anæsthetic, ether, by means of Hewitt's apparatus. The patient was just beginning to pass under the effects of the drug, and was still quite in the early stage of anæsthesia when the pulse and respiration flagged; the operation had not begun. All means of restoration were tried without avail, including the performance of artificial respiration for half an hour, but the patient died at 11.50 a.m.

An inquest was held, and the jury returned a verdict of death from natural causes, and added a rider stating that every possible care had been taken by those in charge of the case. Mr. Thompson and Dr. Lancaster were both present in Court. Dr. Spilsbury made a post-mortem examination, and found that the whole of the pelvic organs where in a state of absolute disorganisation, the bladder being gangrenous, and surrounded by a large abscess-cavity. In addition, the right kidney and ureter were totally destroyed by tuberculosis, and there was recent phthisis.

Pupils' Physical Society.

A MEETING of the above Society was held in the College Smoking-room on January 29th. Mr. J. A. Ryle was in the chair, and twenty-five members were present.

Mr. J. L. M. Symns read a paper on "Night Terrors," which was very keenly appreciated by those present. The following members took part in the animated discussion which followed:—The President, Dr. H. C. Mann, Messrs. Heaton, York Moore, Fawcus, A. J. E. Smith, Morgan, Lawson, Hunt, and both Hon. Secs.

The meeting adjourned at 10.20 p.m.

Some Further Therapeutic Points.

An Address read before the Aldershot Medical Society on Friday, November 1st, 1912, by
HERBERT FRENCH, M.A., M.D. (Oxon.), F.R.C.P. (Lond.).

(*Continued from page 57.*)

The next point that I shall refer it is, perhaps, rather a prognostic than a therapeutic point, but seeing that when one is able to measure the significance of a symptom in a given case the treatment that will be adopted is also liable to vary considerably, I may be permitted, perhaps, to include it here. It concerns

The value of Estimations of the Urea in the Blood in cases of Albuminuria.

Probably in the case of no symptom is it more difficult to assess the degree to which it matters than it is in connection with albuminuria. Not only is one familiar with the transient intermittent albuminuria of young men and women who require absolutely no treatment for it at all, but one also knows that there are cases of organic albuminuria in people suffering from chronic nephritis in which the patients survive for fifteen or twenty years after they have refused altogether to observe any particular precautions as regards proteid dietary, medicinal treatment, and things of that kind, whilst other patients who have not seemed to be so ill as this have nevertheless died with almost unexpected rapidity. It is exceedingly difficult to be able to pick out by physical signs alone those patients in whom the albuminuria matters and indicates the need for strict treatment from those other cases in which, notwithstanding the presence of albuminuria even with renal tube casts and a raised blood pressure, the best treatment is not to insist upon any drastic departure from the ordinary way of living, provided the patient avoids things that are obviously unhealthy.

Again, in the case of elderly men suffering from consecutive nephritis the result of enlargement of the prostate, it is really not at all easy to be sure how good or how bad the kidneys are, and, therefore, to what extent it is worth while resorting to radical cure by removal of the prostate. There are, of course, many different measures now employed to test the renal efficiency; most of these are based upon the oral administration or the injection into a vein of some substance which is excreted by the kidneys and can be detected in the urine—methylene blue, for instance; but even when one has employed these tests one is very often left in considerable doubt as to whether the excretory powers of the kidneys are adequate or not. It used to be held that estimation of the total urea in the urine afforded a measure of the renal efficiency, but from metabolism work done many years ago now in conjunction with Dr. J. A. Butler, I am sure that the urea excretion in these cases runs almost parallel with the nitrogen taken by the mouth, and that it is only when the patient is so ill as not to be able to take much proteid food that the total urea in the urine falls markedly below the normal minimum. In patients who look well, but who, nevertheless, have inadequate kidneys, the urea in the urine may reach a very fair total, and one may draw a very erroneous conclusion as to the renal adequacy from the results of urinary urea analysis. There is, indeed, no single criterion of renal adequacy, but I should like to draw attention to a new one which is likely to be employed fairly widely, and this is the determination of the urea in the patient's circulating blood. In ordinary healthy persons the urea in the blood amounts to something between 10 and 15 parts per 100,000. In cases of serious renal mischief, whether "consecutive" or of the Bright's disease type, or the result of calculous or tuberculous disease, this figure frequently rises to as much as 150 or 200 or 250 parts of urea per 100,000 parts of blood, whilst in rarer instances the figure reaches as much as 500 parts per 100,000. It would be difficult to lay much stress upon a merely small rise above the normal 10 or 15 parts per 100,000, and when one meets with figures such as 20 or 25 parts per 100,000 it does not follow that the kidneys are inadequate. When the figure rises to 75 or 100 parts per 100,000, however, this is a sign of danger, and figures that are higher still are signs of still graver omen. Dr. J. H. Ryffel and I have now investigated a large number of patients in respect to this point, and the above conclusions are definite. The converse is not necessarily true, for in some cases of puerperal eclampsia, for instance, but not in

ordinary uræmia, the urea figure in the blood has been little increased. This supports the view that eclampsia is not due primarily to the inadequacy of renal excretion, but is the result of the formation in the body of abnormal metabolic products, apparently in consequence of pathological changes that take place in the liver as the result of the renal disease. The usefulness of urea estimations in the blood in helping to pick out those cases of cystitis and enlarged prostate that are suitable for operation from those in whom the consecutive renal changes have gone too far is obvious. Some patients with severe pyuria and frequency of micturition may seem to be in too serious a condition for removal of the prostate to be justifiable, and yet, other things being equal, if the urea in the blood is not increased, this affords an argument in favour of operation; whilst, if the urea is much increased, then the clinical evidence afforded against operation by other symptoms and signs is confirmed.

The actual estimations cannot be done by oneself in ordinary practice, but they are relatively simple if the necessary blood is sent to a laboratory where the apparatus required for its analysis is all ready to hand. One takes about 20 c.c. of blood from a vein in the arm by means of a hollow needle and an all-glass antitoxic syringe in precisely the same way that one obtains blood for making bacteriological cultivations. One uses the sphygmomanometer bag as a tourniquet in the way that I shall describe later on. When the veins are standing out prominently and the skin over them has been sterilised, the sharp antitoxic needle attached to the all-glass syringe is plunged directly into the median basilic or the median cephalic vein. The pressure of the blood itself fills the syringe, and in this respect the all-glass variety has a great advantage over other sorts—all bleeding stops as soon as the pressure round the upper arm is released. The contents of the syringe are expelled into absolute alcohol, about 100 c.c. in a suitable glass bottle; the latter is then corked and sent in a protecting tin to the laboratory. The principles of the analysis are as follows: The absolute alcohol precipitates the serum albumin, serum globulin, and fibrinogen, but takes into solution the urea, together with certain other extracts. The amount of absolute alcohol used need not be measured with absolute accuracy, though it is essential to know the exact quantity of blood. On filtering and washing the filter carefully, the filtrate contains the urea. It is evaporated to dryness and the residue re-dissolved in distilled water. The urea goes into solution; along with it there are minor quantities of other nitrogenous substances no doubt, but for clinical purposes at any rate the estimation of the urea by the sodium hydrobromite method, using the original technique, gives a sufficiently constant figure when successive samples of the same blood are analysed to warrant one in making use of the results as a numerical measure of what may be called for short the urea in the blood, though probably just as in the case of the urine the figure obtained represents the urea plus small quantities of nitrogen from other substances. Dr. Ryffel and I are looking forward to publishing the full results of our investigations in due course, but it will probably take several years before we obtain all the statistics we should like from a long series of cases that have been followed through from the time of the first analysis until the final result of the case is known. We already know, however, that the technique is simple, that the patients experience practically no discomfort beyond the initial needle prick in the performance of the test, and that the figures obtained do afford very material assistance in interpreting the degree to which the symptom—albuminuria—signifies.

The last point that I will mention to you to-night concerns

A simple method of Venesection without Incision, by means of a short hollow Needle of wide bore; also the value of the Sphygmomanometer as a Tourniquet.

It may be urged that venesection is so seldom required that it does not need discussion. I think, however, that whereas formerly it was performed to so riotous and unnecessary an extent that it went entirely out of fashion when the reaction against it set in, there are, nevertheless, a considerable number of conditions in which it is not merely a useful, but actually an advisable part of the treatment. It is probable that every year each of us meets with several cases in which venesection ought to be performed. To mention one or two such conditions only, venesection is of immediate benefit in cases of acute dilatation or over-distension of the right ventricle from any cause, whether this is due to organic valvular disease of the heart, such as mitral stenosis, or to obstruction in the pulmonary circulation, such as may result from chronic bronchitis and emphysema, or from fibroid lung with or without bronchiectasis, or to renal mischief or arterio-sclerosis with high blood pressure, or to weakness of the heart muscle itself owing to fibroid changes in it, or to flabbiness from fatty change, or to acute myocardial degeneration from acute rheumatism, pericarditis, or other similar cause. Again, venesection is undoubtedly beneficial in the treatment of acute uræmia whether this is due to acute or chronic Bright's disease or to

puerperal eclampsia. Lobar pneumonia in vigorous young adults with plethoric tendency, if it is associated with congestion and cyanosis, frequently demands venesection, and the result of the treatment often brings refreshing sleep and relief to the patient's distress. Venesection is beneficial again in certain cases of cerebral hæmorrhage, in the relief sometimes of angina pectoris, in the treatment of corresponding abdominal attacks now generally spoken of as angina abdominalis. It is even probable that small blood lettings at intervals of a month, six weeks, two months, or three months are beneficial to certain full-blooded individuals, especially males who live well without taking a sufficient amount of exercise, and who have a tendency to degeneration of the arteries and kidneys. Similar repeated blood lettings also prove beneficial to those who suffer from buzzings in the head, attacks of giddiness, and other cerebral symptoms of arterio-sclerosis associated with high blood pressure. The reason why venesection has gone so much out of fashion is largely, I think, the fact that we do not like to make incisions for the purpose, such incisions requiring careful aseptic dressing. Whereas formerly the mere lancing of a vein was regarded as of no particular moment, since the days of asepsis and antisepsis have come in a skin incision is regarded with greater respect. I find, however, that it is, at any rate in many cases, a far simpler thing to remove blood by vene-*puncture* than it is by vene-*section*, and I have done so now in many cases by means of short, stout, hollow needles made for me by Messrs. Down Bros., and shown in Fig. III.

Each is 2 millimeters in diameter, and the most convenient length 2 centimeters, though it is wise to have a longer one of 4 centimeters also in case one has a very stout arm to deal with. I find, moreover, that the use of the sphygmomanometer which Messrs. Down Bros. make for me greatly facilitates the operation (Fig IV.).

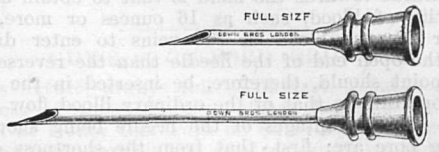

FIG. III.

The rubber bag being applied round the arm, one pumps the air until one can no longer feel the pulse at the wrist. The point at which the pulse ceases to be palpable gives a measure of the maximum systolic blood pressure indicated by the height of the mercury column in the manometer tube. Suppose this to be, we will say, 125 mm. Hg., one can now let out a little of the air until the pressure in the manometer reaches, say, 110 mm. Hg. The pulse can then be felt beating strongly, but the veins are still completely obstructed. Having cleaned the skin over the median cephalic or median basilic vein, according to which is the larger, one now simply plunges the hollow needle directly into the vein, the

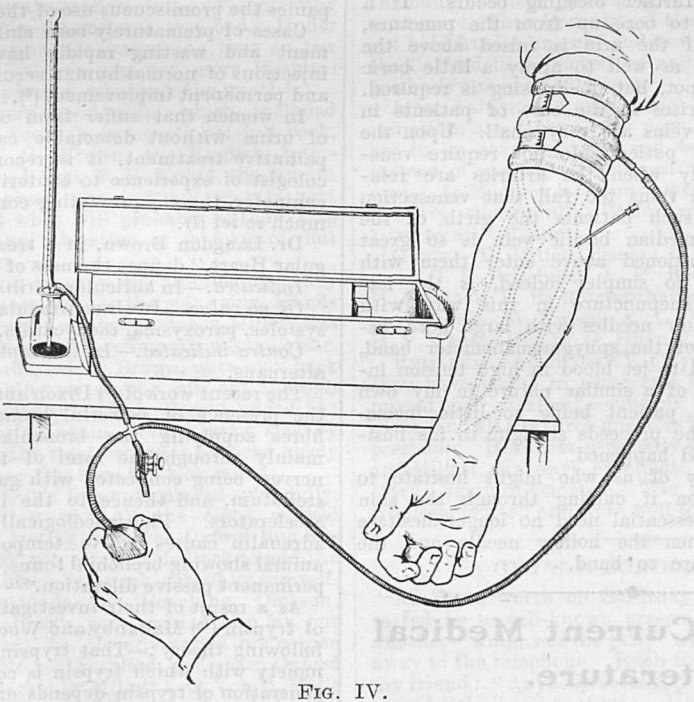

FIG. IV.

point being directed downwards towards the hand and not upwards towards the heart, as is the general rule in taking blood for ordinary blood cultures. The reason for directing the point of the needle downwards towards the hand is that to obtain a large quantity of blood, such as 16 ounces or more, it is better for the blood in the veins to enter directly into the open end of the needle than the reverse way. The point should, therefore, be inserted in the direction opposite to that of the ordinary blood flow in the vein. The advantages of the needle being short and of big bore are: first, that from the shortness of the tube the latter does not become blocked by rapid clotting within it, a trouble which is apt to affect the longer needles of smaller bore that are generally used for obtaining blood cultures; and secondly, that the rate of outflow of the blood into the receiver is so much more rapid that the venesection can be completed to the extent of 12 or 15 ounces in between five to ten minutes, whereas it takes a much longer time than this for the same amount of blood to flow through needles of smaller bore. As soon as the required amount of blood has poured out from the needle, the air within the sphygmomanometer bag is released, the flow of blood from the veins back into the heart at once reduces the pressure within them to a very low figure, and on withdrawing the venepuncture needle no further bleeding occurs. If a few drops still tend to ooze up from the puncture, these stop at once if the arm is raised above the patient's head. It is as well to apply a little boric acid powder to the spot, but no dressing is required. The only difficulty arises in the case of patients in whom the superficial veins are very small. Upon the whole, however, such patients do not require venesection. It is chiefly when the arteries are relatively empty and the veins too full that venesection is required, and in such patients the girth of the median cephalic or median basilic vein is so great that the needles mentioned above enter them with the greatest ease. So simple, indeed, is the letting of blood by venepuncture in this way with the use of short hollow needles with large bore, associated by the use of the sphygmomanometer band, that I am accustomed to let blood in high tension individuals and others of a similar nature in my own consulting room, the patient being so little incommoded that after it he proceeds straight to his business as if nothing had happened.

I think that many of us who might hesitate to perform the operation if cutting through the skin with a scalpel were essential need no longer hesitate in suitable cases when the hollow needle and the sphygmomanometer are to hand.

Notes on Current Medical Literature.

IN his post-graduate lectures on Neurology, Dr. Hinds Powell lays stress on the electrical testing of muscles as a means of diagnosis, prognosis, and treatment. He illustrates his statements by showing how incipient tabes dorsalis may be differentiated from peripheral neuritis, and how the prognosis in cases of facial paralysis may be deduced from the electrical reaction.

The diagnostic value of lumbar puncture is also considered in (*a*) acute diseases associated with meningism, (*b*) establishing the identity of the organism in meningitis, (*c*) the diagnosis of syphilitic and parasyphilitic diseases of the central nervous system.

A writer in "St. Bartholomew's Hospital Journal" (2) in an ingenious essay, maintains that for the habitual smoker tobacco acts as a digestive, laxative, mental stimulant, deodorant, and soporific.

Intestinal Auto-intoxication forms the subject of a lecture an abstract of which (3) is published in "The Polyclinic." Emphasis is laid on the toxicity following the non-oxidation of ammonia, on the presence of increased leucin in the urine as a valuable diagnostic sign of hepatic insufficiency, and the predominance of aërobic bacteria in the pathological colon and appendix. The natural lines of defence of the body against intestinal toxins are given as (*a*) intestinal mucosa, (*b*) liver, (*c*) glands producing internal secretions.

Patients suffering from exophthalmic goitre are said (4) to possess a "hypertrophied conscience" and a "sort of restless virtue."

Much doubt is cast on the value of neo-salvarsan in the treatment of syphilitic lesions by writers in a recent German publication (5), who find, after using it in many cases, that it is less powerful and more dangerous than salvarsan, and is specially contra-indicated in ambulant patients. The complications they have met with lead them to speak strongly of the toxicity which accompanies the promiscuous use of the much-vaunted drug.

Cases of prematurely-born children refusing nourishment and wasting rapidly have been treated with injections of normal human serum, followed by marked and permanent improvement (6).

In women that suffer from occasional incontinence of urine without detectable cause, and who resist palliative treatment, it is recommended by a gynæcologist of experience to cauterize the internal vesical sphincter, thereby promoting contraction and affording much relief (7).

Dr. Langdon Brown, in a treatise on (8) "The Irregular Heart," defines the uses of digitalis—

Indicated.—In auricular fibrillation and flutter.

Of no value.—In sinus irregularity, ventricular extrasystoles, paroxysmal tachycardia, toxic myocarditis.

Contra-indicated.—In incomplete heart block, pulsus alternans.

The recent work of (9) Dixon and another demonstrated the presence of powerful bronchodilator sympathetic fibres supplying the bronchial muscles, proceeding mainly through the rami of the upper three dorsal nerves, being connected with ganglia in the ganglion stellatum, and thence to the lungs with the cardiac accelerators. Pharmacologically they found that adrenalin causes active temporary dilatation in an animal showing bronchial tonus, whilst atropine causes permanent passive dilatation.

As a result of their investigations into the formation of trypsin (10) Mallanby and Woolley have formulated the following theory:—That trypsinogen contains a protein moiety with which trypsin is combined, and that the generation of trypsin depends on the absorption of the enterokinase by the protein moiety of the trypsinogen, digestion of this protein element, and subsequent liberation of trypsin. They also found that the formation of trypsin is stopped by acid, delayed by alkaline, and occurs best in neutral media.

The influence of previous training on the future of the midwife is dealt with in a recent issue of the "Nursing Times" (11). The untrained intelligent woman is claimed to be more scrupulous, more interested, and more "human" in her dealings than the highly-

trained nurse; her drawbacks being her ignorance of ward-management and a tendency to magnify little ailments in the mother and child. The question is full of interest, and undoubtedly has an important bearing in the education of the modern nurse.

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(1) Clin. Journ., Vol. xli., No. 15.
(2) St. Bartholomew's Hosp. Journ,, Vol. liii., No. 1384.
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(4) Clin. Journ., Vol. xli., No. 14.
(5) Münch. Med. Woch., 1912, Vol. lix.
(6) Amer. Journ. of Obstetrics, April, 1912.
(7) Wom. Med. Journ., October, 1912
(8) Med. Review, Vol. xvi., No. 1.
(9) Journ. of Physiology, Vol., xlv. No. 5.
(10) Ibid.
(11) The Nursing Times, Vol. ix., No. 402.

Rugby Football.

GUY'S v. OXFORD UNIVERSITY.

This match was played at Honor Oak Park, on Wednesday, January 29th, but, unfortunately, the day was very foggy, and the atmosphere dull and depressing in the extreme, while the ground was very bad. Under the circumstances it was not surprising that so few spectators turned up; but one expected more Hospital men would have been present, whatever the weather.

Oxford brought a very good side, which included W. M. Dickson, the Scottish International full back, A. J. Dingle, and L. G. Brown, the English Internationals. It was hoped that F. H. Knott, the famous stand-off Oxford half, would turn out, but he was kept away. Guy's had out what will probably be their Cup side. There may be an alteration or so forward, but that remains to be seen.

Oxford were the first to show up prominently, they soon accommodated themselves to the soft going, Hands running well, and from one of these attacks Millett was forced to carry over. Medlock subsequently punted clear, but the Oxford forwards, led by Brown, were soon back again, and Dingle, picking up on the run, cut through to the posts with a good try, which Brown added to; Oxford were soon scoring again, a very lucky kick by Hands sent the ball to the right, where it bounced nicely for Clock to gallop over; this time the kick failed.

After half-time the Guy's forwards played splendidly, they were well together, and all the eight worked delightfully. A good footing near the Oxford line was attained, and Stranack got over for Medlock to add the major points. Soon after Stranack got off by himself, with Medlock in attendance. Reaching Dickson, Stranack passed. Medlock's pace carried him far, but fearing Dingle's pursuit, he cleverly varied his course and crossed far out. No goal resulted, and again Oxford replied, only a lovely tackle by Millett kept Von B. Melle out. Guy's pack then pressed hard, and just on time Danby was awarded a try. Medlock's kick was good, but not quite successful. Thus a splendid game ended. Guy's, 1 goal, 2 tries (11 points); Oxford, 1 goal, 1 try (8 points).

GUY'S.—H. Millett (back); C. L. Curle, A. H. Harkness, G. B. Pritchard, A. F. Rook (three-quarters); C. H. Medlock, L. R. Broster (halves); C. S. L. Roberts, W. S. Stranack, O. Parry-Jones, M. Tweed, A. B. Danby, A L. Liebson, H. P. Whitworth, L. Llarena.

REMARKS.—All played well, but special mention should be made of Medlock's display. His extraordinary faculty of being always where wanted was never more apparent. The try following his long run is rapidly becoming a feature of each match. Millett's full-back play was perfect.

GUY'S v. CATFORD BRIDGE.

This fixture, always full of interest, because of the nearness of the respective clubs' headquarters, was played at Honor Oak Park on Saturday, February 1st. The day was a terrible one, rain persistently falling, and the ground becoming more like a morass as the game proceeded. But few supporters faced the weather. Those that did turn out were rewarded by a game that was, under the conditions, simply wonderful. For years Catford have had a great pack, and this year is no exception; their forwards played finely, but their backs were poor. They have a big list of injured, and to add to their troubles Broster was right on the top of his form. Combining well with Medlock, he got the backs on the move constantly. The first try came after the three-quarters had handled skilfully, by Rook cross-kicking and Medlock securing, handing smartly to Broster the old Blue scored. Medlock failed by inches at the kick, but he converted all the subsequent tries, a great achievement considering the weight and greasiness of the ball. Perfect passing sent Pritchard over with the next score. Then from almost the Catford posts, Medlock got hold from a line out and dashed off. He punted over the Catford back, kicked on and fell on the ball for as good a try as one could wish.

After half-time Curle using his weight and determination, aided by a very useful swerve, touched for a try in an easy position, and before the end Broster, instead of passing out, slipped through cleverly on his own. As Medlock had done all the goal kicking, bar the first try, successfully, Catford were beaten by 4 goals, 1 try to nil. Team:—

GUY'S.—H. Millett (back); C. L. Curle, A. H. Harkness, G. P. Pritchard, A. F. Rook (three-quarters); C. H. Medlock, L. R. Broster (halves); W. S. Stranack, O. Parry-Jones, M. Tweed, A. L. Anthony, A. B. Danby, H. P. Whitworth, W. G. Haynes, F. J. Biddle (forwards).

REMARKS.—Again the XV. played well, and from the way they have lasted in these two last matches they have proved their excellent condition. Broster played a grand game, and all the three-quarters handled with marvellous precision. Harkness especially was very safe. Medlock and Millett, as always, excellent. Medlock's long distance "try" again in evidence. The forwards exhibited very wholesome dash and were well together.

GUY'S v. LONDON WELSH.

At Wandsworth on Saturday, February 8th, I was seated by a well-known pressman. Next to him was another "knight of the pen," who was frequently called away to the telephone. Each time he returned he asked my friend: "Anybody scored"? the reply came: "Only the whistle," and so it was. It's a wretched unsporting task to criticise the referee, but it appeared that nothing was right. "Foot up," "offside," "lying on the ball," all came alike, and so the solo went on till one came to the conclusion. Guy's got one try, scored by brilliant work to commence with on the part of Curle, who handed to Harkness; Medlock being in attendance as usual, received; and away he went to score that long distance try, which sooner or later appears in every game.

The conversion was very difficult, and Medlock just missed the posts. Till quite the end my friend's remark was right, it was: "nobody scoring except the whistle," but wedged in between was much good play on both sides. The Welsh interpassing was, at times, well done, and only thorough tackling kept them out. Twice in succession the Guy's three's worked out to their wingmen, but each time, when Medlock gathered from the cross kick, he was ruled offside. At half-time, or rather just before, Pritchard marked, but it was not apparently given, and Pritchard's surprise was great when he found that his momentary wait was construed into him not playing the ball and a penalty against him awarded.

The second half was noticeable, because of the many times that Maddocks got away on the left, but each time Millett accounted for him. The Welsh wing, though consisting of Maddocks and Leigh, was very troublesome. Guy's developed one or two attacks to the right, but nothing came of them. Now and again they looked dangerous, but somehow the movements were slow and lacked completion.

Just before the end Leigh ran very strongly, but on the line almost Millett and Harkness between them got him down. At once for some reason a penalty was awarded, and Leigh had no difficulty about goaling. Soon after, somewhat to the relief of all, the long whistle went and the game was left drawn. Guy's, 1 try; London Welsh, 1 penalty. Team:—

GUY'S.—H. Millett (back); C. L. Curle, A. H. Harkness, G. B. Pritchard, A. F. Rook (three-quarters); C. H Medlock, L. R. Broster (halves); C. S. Lane-Roberts, W. S. Stranack, O. Parry-Jones, M. B. Tweed, A. B. Danby, H. P. Whitworth, L. Llarena, M. B. Haynes (forwards).

REMARKS.—It is difficult to play one's best when one is always being pulled up, but the pack were not so solid as usual. Roberts, Stranack and Parry-Jones, also Whitworth, were very good indeed, but as an eight they were a little straggly. The passing of the backs was obvious, just a little more of the unexpected among the three-quarters, a little more compact playing among the forwards, and we can face the Cup Ties with confidence.

Hockey.

GUY'S v. EAST SHEEN.

This match was played on Saturday at Kew. The papers had prophesied that Guy's would be routed but, contrary to expectations, the result was a draw of 3 goals each. The game was played in rain as usual, but the ground was pretty good except for the goal areas. East Sheen scored first after 15 minutes of very fast and even play. Five minutes later they scored again. Then, after continued pressure by Guy's in our opponents 25, Poulton scored, and ends were changed with East Sheen leading 2–1. During the second half Burnside had to save from several very good shots, but was finally beaten while lying in the mud, having fallen in clearing a previous shot. After this, Guy's did most of the pressing, and scored again through Poulton. We continued to press after this, but several shots were faulty. Parry got in some splendid centres, but Bromley shot just outside the post, and Peregrine mis-hit. It was not until the last stroke of the game that Vincent-Browne scored after previously shooting over the cross-bar. Team:—

GUY'S.—B. Burnside (goal); G. D. Gripper and O. G. Morgan (backs); H. N. Purdom, R. W. P. Jackson, and C. R. Smith (halves); J. H. Parry, H. L. Peregrine, E. P. Poulton, L. Bromley, and C. Vincent-Browne (forwards).

REMARKS.—We were glad to see Morgan back again in the team, and although he has not played lately, he seemed in good form and lasted well. Burnside saved remarkably well in goal, and also cleared well. Our defence was better than our attack and did very well, as we were playing against one of the best lines of forwards we have met this season. The chief weakness in the forwards seemed to be in shooting: there were two or three occasions on which we certainly ought to have scored. We missed the shooting ability of our Captain Graham who was unable to play. Vincent-Browne, as usual, managed to shoot one over the cross-bar. He has done this on several occasions lately.

GUY'S v. NORTHWOOD.

Played at Raynes Park, on Saturday, February 8th. The ground was dry and the weather fine, and consequently a very fast game resulted. Guy's lacked the services of Graham and Coxon, and as Burnside also was unable to take Coxon's place, we played H. Lee as a third back. Guy's were far superior to their opponents, and won finally by 6—2. Vincent-Browne opened the scoring, and Poulton and Parry added one each before half-time, while our opponents' inside right scored with a clever shot.

After half-time our opponents pressed hard for a little, but Jackson relieved and Guy's took the ball to the other end and Bromley scored. Northwood replied with another goal, which was obviously off-side but was not given—in the absence of a referee. Later on, Vincent-Browne scored a goal which was disallowed, and then Poulton scored again, bringing our total to 6. Parry scored twice before time, but both were disallowed on account of sticks.

GUY'S.—O. G. Morgan (goal); H. Lee, G. D. Gripper (backs); C. R. Smith, R. W. P. Jackson, H. N. Purdom (halves); C. Vincent-Browne, L. Bromley, E. P. Poulton, J. H. Parry, H. L. Peregrine (forwards).

REMARKS.—Guy's did not play well in this game, but much may be put down to the fast and bumpy turf which spoilt accurate stick work. The halves were very weak and slack, and both backs and forwards were spasmodic. Poulton was not up to his usual form, and Parry missed two or three shots during the first half, but otherwise played well. He must get out of "sticking." There was a tremendous difference between our display on the 8th and that against East Sheen, which seems to emphasise the fact that we play far better on a good ground and against a good team.

Births.

DARKE.—On February 9th, at 3, Pownall Gardens, Hounslow, the wife of Sydney J. Darke, M.B., B.S., of a son.

HUGHES.—On February 2nd, at 37, Queen Anne Street, Cavendish Square, W., the wife of E. C. Hughes, M.C. Cantab., F.R.C.S. Eng., of a daughter.

Marriage.

GREENWOOD–COBELY.—On February 8th, at Christ Church, Crouch End, by the Rev. C. J. Sharp, M.A., Arthur Atkins Greenwood, M.B., B.S., of 55, Crouch Hall Road, Crouch End, only son of Dr. and Mrs. Greenwood, of "Hatherleigh," Crouch End, to Phyllis, elder daughter of Mr. and Mrs. Frank Cobely, of 108, Hazellville Road, Hornsey Lane, N.

Ed.—F. G. L. S.

GUY'S HOSPITAL GAZETTE.

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Passim.

IN the present issue will be found the concluding number of the admirable series of articles which have appeared under the title of "London Bridge and the Borough in the Eighteenth Century." Although the series has been a long one, not a few will share with us the opinion that it has ended all too soon. Mr. Wingent, the author, deserves the highest praise, and the GAZETTE and its readers are to be congratulated on their acquirement of the fruits of his labours. The task of historian is one of the hardest of tasks, not only in so far as it necessitates laborious research, but further in that it demands, for success, the combined qualities of accuracy and literary capability. With both of these qualities Mr. Wingent appears to be well endowed, for his facts throughout have been arranged on the most secure footing, but, nevertheless, have not once merited that accusation, so frequently levelled at facts, namely, that they are too "dry."

Without being lured from his path, and without recourse to elaboration or repetition, Mr. Wingent has succeeded in rendering readable, in the fullest sense of the word, a tabulation of events which, in less skilful hands, might scarcely even have deserved the distinction of publication.

On occasions, and always in the best of taste, he has called humour to his aid, and in so doing has adopted a device which only serves to make the solid material stand forth in still clearer relief. In his employment of quotations he has shown great wisdom. Over-quotation is one of the pit-falls of the recorder, but one which Mr. Wingent has, in the main, adroitly avoided. Furthermore, his borrowings from other authorities have been consistently apposite, and employed with wise discrimination. His choice of initiatory quotations to the several chapters has been particularly happy, and in all his writings his artist's eye for effective representation of his subject has proved a valuable ally to his pen.

Of such sterling worth, viewed both generally and in detail, do we believe Mr. Wingent's History of the Borough to be, that we hasten to take this opportunity of voicing a hope, which has already been emphatically expressed in many quarters, that it may be found possible to collect and publish in book form the component parts of the series.

We would point out that such a procedure would not only ensure a proper permanency for the product of Mr. Wingent's arduous researches and careful writing, but further that it would enable Guy's men, and many others, too, who may be interested in the period or localities dealt with, to become possessors of a volume of no small historical value. Such a volume would, we believe, be a worthy companion to Wilks and Bettany's History of Guy's Hospital, and would certainly find for itself an honoured place among the long list of books by Guy's men.

In his concluding sentences Mr. Wingent observes that "the purpose of these articles

has been to stimulate an interest in the history of the locality, and in particular of the Hospital itself, in order to smooth the way to the creation of a small museum for the preservation of the antiquities of Guy's."

The inauguration of such a museum is a scheme very near to Mr. Wingent's heart, and one to which he has devoted a great amount of time and consideration. We are glad to be able to announce that plans are already afoot for the institution of the museum, and that, chiefly through Mr. Wingent's own devoted endeavours, the realisation of his dream is close at hand.

It is with extreme regret that we learn of the death in the Antartic of Lieutenant Ninnis, whose father, Inspector-General Ninnis, and whose brother are both of Guy's. Science and Discovery have claimed a heavy toll of late, and the toll seems all the heavier and harder to pay when young lives are concerned. The expedition in which Lieutenant Ninnis (whose father before him was an explorer in a similar field) took part, was purely scientific in aim, and it would appear that by his death science has lost a figure of exceptional promise and the world a man of undoubted courage and ability. The relatives of Lieutenant Ninnis have our very sincere sympathies in their bereavement.

We observe with gratification that a reform, which has been repeatedly advocated in these columns, has at last been carried into effect. Printed papers containing advice for patients suffering from venereal disease have now been sanctioned by the Committee, and are supplied in the Out-Patient Departments. The Gazette may, we think, take some credit to itself for the initiation of the scheme, and Miss Patterson (late Sister in Out-Patient's), whose fearless advocacy of the reform contributed not a little to its introduction, must not be forgotten.

In an age in which Preventive Medicine is destined to play an important part, such small beginnings as these may be regarded as the pioneers of other and greater reforms to follow.

To those who have objected, on the score of the rarity of syphilis insontium, that the reform in question was not necessary, we would reply that the occurrence of a single case would be ample justification for the innovation. Moreover, we would point out, and a perusal of the instructions will show, that the aim is not by any means solely the eradication of the innocent infections.

The value of the various special appointments now obtainable at Guy's has already been so fully established that the creation of a new one is, perhaps, worthy of special notice. In future there will be appointed two Pathological Assistants to the Demonstrators of Morbid Anatomy, to hold office for six months —*one being appointed each three months*— who shall also be eligible for re-appointment. The appointment is analogous to the old one of Section-cutter to the Surgical Registrars, but will be an improvement thereon. If his work has been satisfactory, each assistant will receive at the end of his appointment an honorarium of £5 5s.

The work should provide an excellent combination of instruction and interest, and should prove most valuable to prospective examinees, and, perhaps, to intending specialists in the domain of morbid anatomy. Full particulars of the appointment can be obtained in the Medical School Office.

The final meeting for this session of the Debating Society has been postponed from Thursday, March 6th, to Thursday, March 13th, when the subject for discussion will be:— "That in the opinion of this House Hospitals should be Financed by the State." Mr. T. B. Heaton and Mr. G. T. Mullally are "billed" to appear for the proposition, and their opponents will be Mr. G. S. Miller and Mr. H. C. Rook. We should like to take this opportunity of congratulating the Society on the success of the Ladies' Night Debate, an account of which will be found on another page. The whole discussion went with a swing, for which the ladies themselves were, to a great extent, responsible. The fact that the Society was out-numbered by its

visitors, however, calls for some comment. Surely on these special occasions a little more interest and enthusiasm might be displayed. The unanimous enjoyment which the function invariably occasions should be ample advertisement of its excellence. J. A. R.

Papers by Guy's Men.

A. S. Blundell Bankhart, M.C., F.R.C.S.: On the Treatment of Club-Foot in Early Childhood.—*Clinical Journal*, 5th February, 1913.

A. E. Boycott, M.D., and C. Price-Jones: Experimental Trypanosome Anæmia (from the Pathological Department, Guy's Hospital).

Fleet-Surgeon Robley Browne, R.N.: A Case of Plague at Shotley.—*Health of the Navy*, 1911.

F. Cook, M.B., B.S., B.Sc., and M. S. Pembrey, M.A., M.D.: Observations on the Effects of Muscular Exercise upon Man (from the Physiological Laboratory, Guy's Hospital).—*Journal of Physiology*, Vol. xlv., No. 6.

Norman Flower, M.A., M.B., B.Ch.: Apyrexial Typhoid.—*British Medical Journal*, 8th February, 1913.

A. C. Jordan, M.D., M.R.C.P.: Intestinal Stasis.—*The Practitioner*, February, 1913.

W. Arbuthnot Lane, M.S., F.R.C.S.: Chronic Intestinal Stasis (with Discussion). Delivered before the Medical Society of London.—*Clinical Journal*, 12th February, 1913.

F. W. Langridge, M.R.C.S., L.R.C.P.: Clinicalia.—*Clinical Journal*, 5th February, 1913.

Lieutenant D. Reynolds, R.A.M.C.—A Case of Hypertrophic Stenosis of the Pylorus in an Adult.—*Journal of R.A.M.C.*, February, 1913.

R. H. Jocelyn Swan, M.S., F.R.C.S: A Clinical Lecture on Tumours of the Kidney (delivered at the Cancer Hospital, Brompton, 29th January, 1913).—*Lancet*, 8th February, 1913.

A. H. Tubby, M.S., F.R.C.S.: A Case of Suppurative Post-Typhoid Osteitis Thirteen years after an attack of Enteric Fever.—*Lancet*, 1st February, 1913.

H. M. M. Woodward, M.R.C.S., L.R.C.P., and K. B. Clarke, M.R.C.S., L.R.C.P.: A Case of Infection in Man by the Bacterium Prodigiosum.—*Lancet*, 1st February, 1913.

W. J. O. Dawson, L.D.S. Eng.: The Dental Department of the Southampton Dispensary. Read before the Annual Meeting of Wessex Branch B.D.A. at Southampton on October 12th, 1912.—*British Dental Journal*, 15th February, 1913.

REPORT OF CASE.

T. D. M. Stout, F.R.C.S.: Mobile External Semilunar Cartilage.—*British Medical Journal*, 22nd February, 1913.

MEMORANDA:—

Cecil Worster-Drought, M.R.C.S., L.R.C.P.: Empyema in an Infant.—*British Medical Journal*, 1st February, 1913.

Notices.

JUNIOR PRIZES FOR GENERAL PROFICIENCY, 1912-1913.

Students who commenced their dissections in October last, and are desirous of competing for the above prizes, are reminded that they must give written notice to the Dean on or before the 25th inst. Forms of application can be obtained at the Medical School Office.

MICHAEL HARRIS PRIZE FOR ANATOMY.
SANDS COX SCHOLARSHIP FOR PHYSIOLOGY.

Students desirous of competing for the above prizes are reminded that they must give written notice to the Dean on or before the 25th inst. Forms of application can be obtained at the Medical School Office.

GOLDING-BIRD GOLD MEDAL AND SCHOLARSHIP FOR BACTERIOLOGY.

Students desirous of competing for the above prize are reminded that they must give written notice to the Dean on or before the 26th inst. Forms of application can be obtained at the Medical School Office.

PRIMARY F.R.C.S. EXAMINATION.
MAY, 1913.

Special Classes, suitable to the requirements of candidates for the above examination, are now in progress, and will continue until the completion of the examination in May. These classes will be held as follows:—

ANATOMY.—Mondays, Wednesdays, and Saturdays, at 9.30 a.m. First class: Monday, the 24th inst.

PHYSIOLOGY.—Tuesdays, Thursdays, and Fridays, at 10 a.m. First class: Tuesday, the 25th inst.

Daily tuition will be given, with practice, in *viva-voce* examination and in the writing of papers.

In Physiology, short revision practical classes will be held in Histology, and in Experimental and Chemical Physiology.

In Anatomy, the large collection of dissections will be studied in order.

The fee for each Course, in either subject, is £2 12s. 6d.

Guy's Hospital, H. C. CAMERON.
11th February, 1913.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.
LICENCE IN DENTAL SURGERY.

Notice is hereby given that every student who commences recognised professional study on or after 1st October, 1913, will be required to pass the Preliminary Science Examination, or some other examination recognised as equivalent thereto, before attending the courses of study laid down in the regulations for the Second Professional Examination.

S. FORREST COWELL,
12th December, 1912. Secretary.

Notes on some of the Hospitals of Paris.

I.

I suppose none of us go to Paris without wondering what the conditions of Hospital life are there; but for some reason, fear of our ignorance of the language, or fear of being regarded as intruding strangers, most of us visit Paris many times without ever passing through the gates of any of the Hospitals.

Perhaps, then, it will not be out of place if I write a little about the position, hours, and general usages of some of the Hospitals, as it may be of some use to Guy's men who have never visited them, but will do so in the future. First, as to introductions. An introduction to a particular surgeon or physician may be a very useful thing, but unless your knowledge of French is exceptionally good it may at times turn out to be a heavily disguised blessing; it is always well to present your card to the chief on your first visit, but beyond this ordinary courtesy nothing is necessary. All the Hospitals are as open to the student and medical man as are those of London, and if one arrives armed with a visiting card, and a knowledge of what one wants to see (surgical operations, nervous cases, cardiac cases, or anything else), one will always find porters, nurses, and students ready to direct one to one's destination. The language should deter no one; the smattering of French one remembers from school is sufficient for one's necessities, and technical terms are almost the same in both languages; moreover, the French surgeon operates in complete silence, so that there is small strain on one's vocabulary when watching him.

The hours of work present greater difficulties; at most Hospitals the cliniques and operations begin between 9.30 and 10 a.m. Ten o'clock in the morning is not the best of hours even in London, and in Paris it becomes a considerable strain. Moreover, as the distances between the Hospitals are considerable, it is not possible to stay anywhere close to more than one, or two at most; which means half-an-hour's journey to any other. In this connection it must be remembered that the "Métro," the underground of Paris, is, nowadays, a very excellent affair; one can easily reach almost any point in Paris on the Métro, and it is always advisable to have a map of the system in one's pocket.

The Hospitals I visited chiefly were the Salpetrière and the Pitié, which lie side by side near the Gare d'Orleans; the Beaujon, which is near the Arc de Triumphe, the Enfants Malades near the Gare Montparnasse, and the Bichat, which is at the Porte Sainte Ouen in the extreme North of Paris, beyond Montmartre. This last is very difficult to reach unless one goes by the new underground, the "Nord-Sud," one of whose branches takes one almost to the door of the Hospital.

In addition to these, the man who is interested in neurology will want to visit the Bicêtre, and there is much good surgical work to be seen at the Larriboisière, near the Gare de Nord.

Babinski's Clinique is held at the Pitié, one of the most modern of the Hospitals of Paris; going past a long Out-Patient Department, and beyond several buildings occupied by laundry, machinery, and residents quarters you come to eight big buildings, each of which covers a ground space equal to that of our medical block, but which are only two stories in height; they are joined up by smaller buildings in which are kitchens, bathrooms, and sometimes large theatres and gymnasia. The Clinique is in a long narrow room in one of these smaller buildings, very comfortable and clean, with a row of chairs on a platform at one side for Students, and a table and group of chairs at one end for the Professor and his "firm."

All the "firm," about a dozen men and girls, wear white overalls and aprons; there is a pleasant informality about all the work; one of the girls sits on the table and talks vigorously to all the men around, and afterwards repeats her story to Babinski at great length and evidently to his appreciation. He is a big, handsome man with the keenness that seems to mark all the French savants, and with a geniality that is much rarer; he talks to every member of his firm as to an equal; if one of the "internes" comes in late, the chief will always pause for a hurried handshake before returning to the case. Nothing disturbs him; when the battery breaks down in the middle of an investigation, he abuses the dresser genially, and the latter makes voluble excuses. Babinski has all the signs of a great man.

Just after he had begun to go over the first case (a little man who looked rather cold, with nothing on but a cotton shirt with a design like red Tiddlywinks) a sister came in to announce the arrival of a distinguished neurologist from Bordeaux. As he was ushered in everyone rose to their feet, he was a thin man whose complexion suggested pernicious anæmia, his face was impassive like a mask, he wore a tightly buttoned frock-coat which made him look thinner and more puppet-like than ever. He came slowly down the room and bowed to Babinski—very stiffly from the hip-joints, keeping the back straight. Babinski received him with great deference, and after he had been introduced to the Chefs-de-clinique everyone sat down again.

The little man with the Tiddlywinks on his shirt had disappeared. Babinski said that he could think of nothing interesting to exhibit; suddenly he thought of something, "Ah! bring Vinot!" he said; several attendants hurried away. While they were gone Babinski told us that this was a patient suffering from what he described as "cerebellar catelepsy," the patient had keratitis in the right eye; there was right-sided facial paralysis, and paralysis of the right vocal cord.

At this moment Vinot was brought in, stark naked, by two attendants; he was carried forward in a chair and put down in front of Babinski and the visitor. Having shown off his facial paralysis and his slurring speech, Babinski told him to touch his nose—the man seemed to go off like a rocket, his hand shooting off in all directions before settling down on his nose; this performance was

so satisfactory that it had to be repeated several times. He was then told to walk, and was supported by two attendants as he stood up; on starting to walk his right thigh was suddenly wrenched up till it nearly touched his abdomen, and then as explosively shot out so that the foot crashed on to the floor, the left leg going through the same performance, and the whole process being repeated four or five times with diminishing intensity; but during these half dozen steps his trunk had remained inert, supported by the attendants who had to drag it along in pursuit of the flying legs, never catching up, however, and inevitably he would have fallen if unsupported. It must not be supposed that Vinot enjoyed all this, on the contrary whilst "walking," he growled and snarled at his attendants rather like a wild beast, but the performance was much too fascinating for anyone to mind his lack of enthusiasm. He was then made to lie on his back with his legs separated; on being told to sit up his legs rose into the air until at right angles to the trunk. Babinski told us that instead of tiring and dropping as an ordinary patient's would, they would remain in this position for ten minutes or more; not only did he tell us it but he proved it, and for ten minutes Vinot lay in this position without moving. He was then carried out.

The other cases seemed dull in comparison. Babinski has a new test for cases where the labrynth is affected. A strong galvanic current is applied to both mastoid processes, and if there is labrynthine trouble, there is nystagmus and vertigo, the patient falling over towards the positive pole; the test being found very valuable in the differential diagnosis of cerebellar conditions. Babinski demonstrated this on several cases, but before doing so, he showed the effect on five normal patients—there being no vertigo even when the current was so strong as to make them scream. This clinique is held every day of the week, and appeared to me to be the very best for anyone interested in nervous conditions.

The cases have all been seen by the internes before they reach Babinski. I was interested to see that the Professor himself never makes a routine examination of these cases; he hears the report, and then goes immediately to the important point.

There can be no doubt that the system of seeing the patients completely stripped is very valuable for diagnostic purposes.

Babinski seldom seems to concentrate his attention on the invocation of one particular sign; for example when obtaining arm-jerks he will be watching for sympathetic contractions in the opposite arm; he will obtain the plantar reflex by pinching the skin over the ankle-joint; he will pinch the patient in many places apparently in order to see what will happen; he will talk to his chef-de-clinique about some quite extraneous subject, and at the same time continue to rain blows on the patient's patellar tendon. When one has watched him for a while one begins to realise how it was that he discovered so extraordinary a thing as the plantar reflex.

T. I. B.

Appointments.

Royal Navy

Surgeon H. M. Langdale has been appointed to *Devonshire* on completion, 12th February, 1913.

R.A.M.C.

The following Lieutenants to be Captains, 31st January, 1913: V. P. Hutchinson, P. C. Field, A. G. Jones.

Lieutenant G. A. Blake has been confirmed in his rank.

Special Reserve R.A.M.C.

Travis Hampson, Gent., to be Lieutenant on Probation, 14th January, 1913.

Territorial Force.

1st Home Counties R.A.M.C. Captain Arthur T. Falwasser resigns his commission, 8th February, 1913.

Civil.

K. W. Goadby, M.R.C.S., has been appointed Medical Referee under Workmen's Compensation Act, 1906, for County Court Circuits 35, 37, 38, 40, 41, 42, 43, 44, 45, 47, 48, 49, 50, with a view to being employed in cases of Industrial Diseases (except ophthalmic cases, and cases of beat-hand, beat-knee, and beat-elbow).

H. L. Hopkins, M.B., B.S. Lond., has been appointed House-Physician at the City of London Hospital for Diseases of the Chest, Victoria Park, E.

W. H. Robinson, M.B., B.C. Cantab., has been appointed Medical Officer to Skipton Union Infirmary.

Birmingham University.

Mr. Montagu Hopson has been appointed External Examiner in Dental Subjects in the University of Birmingham.

Change of Address.

A. H. Crook, M.C., F.R.C.S., from 20, Gildredge Road, Eastbourne, to The Goffs, Eastbourne.

Hubert V. Leigh, M.R.C.S., L.R.C.P., from Guy's Hospital, to Glyn Bargoed, Treharris, R.S.O., South Wales.

A. E. F. Peatty, L.D.S., from 207, Broad Street, Birmingham, to 127, Queen Street, Cardiff.

W. H. Robinson, M.B., B.C., from Stanley House, Skipton, and Landieu, Harthim, Stockton-on-Tees, to 28, Newmarket Street, Skipton. Telephone 35.

R. G. Heegaard Warner, L.D.S., from 271 to 248, Brockley Road, S.E.

W. S. Stranack, L.D.S., from Guy's Hospital, to 18, Stratford Place, W.

F. R. Wallis, L.D.S., from 22, Museum Street, Ipswich, to Bristol Royal Infirmary, Bristol.

Correspondence.

To the Editor of Guy's Hospital Gazette.

Westminster Abbey Service Committee.

Dear Sir.—May I use your columns to call the attention of your readers to the annual University of London service on Presentation Day, May 7th, at 6 p.m., which will be held this year, as in previous years, in Westminster Abbey? It is hoped that the Rt. Rev. Bishop Boyd-Carpenter will preach the sermon.

It is desired to make the congregation at the service as representative as possible of every section of the University. The procession usually includes the Chancellor and Vice-Chancellor, the Chairman of Convocation, the Member of Parliament for the University, the Principal of the University and the Heads of many of the Colleges, and a representative body of Doctors; and it is hoped that this year as in past years there will be a large attendance of graduates and undergraduates, both men and women. Last year the total number present was over a thousand.

Applications for tickets for the service should be addressed to me at 88, Gower Street, W.C., and a stamped addressed envelope should accompany the application. Applicants should state what degree, if any, they possess.—Yours truly, J. DUDLEY WHYTE,

Organising Sec. Westminster Abbey Service.

88, Gower Street, W.C.

February 12th, 1913.

Dispensary and Pharmaceutical Laboratory Report for 1912.

The total number of Out-Patient attendances at the Dispensary during 1912 was 197,557, compared with 220,591 in 1911, 221,847 in 1910, 203,445 in 1909, and 198,332 in 1908.

These are classified for the last two years as follows:—

NUMBER OF DISPENSARY ATTENDANCES.

1911	Medical.	Surgical.	Casual.	Total.
Paying ...	65.410	31,411	64,542	161,363
Free ...	10,363	6,598	42,267	59,228
Total ...	75,773	38,009	106,809	220,591
1912				
Paying ...	70,622	35,581	42,207	148,410
Free ...	13,831	7,799	27,517	49,147
Total ..	84,453	43,380	69,724	197,557

The most noticeable feature of this Table is the large decrease in the number of Casual or Front Surgery cases, amounting to the very large number of about 37,000. This is to be ascribed to the new arrangements in connection with treatment in the Front Surgery whereby patients attending do not necessarily receive a prescription for medicine, but are referred for treatment to the general Out-Patient Department.

The figures seem to indicate that of these 37,000 about 9,000 attended and were treated medically, 5,000 were treated surgically, while the difference between 37,000 and 14,000, *i.e.*, 23,000, did not attend again.

It is interesting to note how this change has affected the receipts from Out-Patients. It will be seen in the following Table that they have fallen by £200.

	1912. £ s. d.	1911. £ s. d.
Out-Patients	1,841 12 3	2,042 7 9
Sale of Drugs	173 16 11	143 10 0
Net Profit on Sale of Bottles to Out-Patients ...	75 5 6	92 2 2
Goods supplied to the Medical School ...	73 4 5	88 16 4
Goods supplied to the Dental School	81 5 0	70 18 6
Goods supplied to the Institution	17 7 0	19 5 3
	£2,262 11 1	£2,457 0 0

The new arrangements have been, on the whole, markedly beneficial to the smooth working of the Dispensary. In previous reports attention was drawn to the time at which patients arrived at the Dispensary; it was shown that about one-third of the total number of Out-Patients attended at the Dispensary after 5 p.m., and the danger owing to this rush of work was pointed out. It can be recorded that the new arrangements have resulted in the attendance of a much smaller proportion of Out-Patients after 5 o'clock. On an average they now amount to about one-sixth of the total number.

Chemicals have been supplied to the various departments to the value stated below:—

	1912. £ s. d.	1911. £ s. d.
Skiagraphic Department ...	14 5 7	10 11 2
Medical Skiagraphic Department	48 18 7	32 8 7
Works Department	12 14 2	10 19 6
Laundry	0 14 3	0 16 9
Total	£76 12 7	£54 16 0

The total cost of Drugs and Dressings during the last two years is given below from figures supplied by Mr. Williams, Clerk to the Governors.

	1912. £ s. d.	1911. £ s. d.
Drugs	3,520 0 0	3,286 0 0
Dressings ...	3,070 0 0	3,192 0 0
Total ...	£6,590 0 0	£6,478 0 0

It was anticipated that the decrease in the number of Out-Patients would result in a corresponding reduction in the cost of drugs. The reason that this is not the case is that, in many cases, there has been a tendency to raise the cost of drugs in accordance with the increased cost of other commodities, such as coal, etc., and although less drugs have been used the cost has been greater.

ANÆSTHETICS.

	Quantity Bought. 1912.	Quantity Bought. 1911.	Cost. 1912. £ s. d.	Cost. 1911. £ s. d.
Absolute Alcohol	95 lbs.	236 lbs.	19 11 1	44 0 3
Chloroform	864 lbs.	214 lbs.	59 2 2	65 19 11
Cocaine and Its Salts	17 ozs.	13 ozs.	9 10 3	7 5 7
Ether	1,238 lbs.	1,055 lbs.	118 8 11	103 4 0
Ethyl Chloride	24 doz.	25½ doz.	20 5 0	19 3 2
Eucaine Lactate	4 ozs.	3 ozs.	1 12 4	1 4 3
Nitrous Oxide	38,100 gals.	30,300 gals.	64 6 3	47 18 9
Novocaine	—	—	7 8 2	4 2 6
Stovaine	—	—	0 1 8	—
Total			£300 5 10	£292 18 5

In addition to the Ether used for Anæsthesia, 13 cwt. costing £56 have been used, largely in the manufacture of Ether Soap, of which 264 gallons have been made.

ANTISEPTICS.

	Quantity Bought. 1912.	Quantity Bought. 1911.	Cost. 1912. £ s. d.	Cost. 1911. £ s. d.
Acid Boric	28 cwt.	29 cwt.	35 16 0	36 11 0
Acid Carbolic	28 cwt.	23 cwt.	108 1 0	51 17 4
Chinosol	10 lbs.	10 lbs.	5 4 2	5 6 10
Cresol	245 gals.	328 gals.	28 11 2	27 6 8
Formaldehyde	686 lbs.	695 lbs.	13 15 0	12 1 3
Hydrogen Peroxide (20 vols.)	688 gals.	596 gals.	64 11 8	55 13 3
Iodoform	42 lbs.	52 lbs.	24 6 6	29 18 0
Lysol	949 gals.	893 gals.	168 3 6	165 0 7
Mercuric Chloride	56 lbs.	59 lbs.	6 19 5	8 0 10
Do. Tablets	—	—	1 0 0	—
Mercuric Iodide	6 lbs.	4 lbs.	3 1 10	1 10 0
Total			£459 10 3	£393 5 9

The only feature of interest in this table is the increase in the cost of Carbolic Acid, which cost 9¼d., against 5d. per lb. in 1911.

DRESSINGS.

	Quantity Bought. 1912.	Quantity Bought. 1911.	Cost. 1912. £ s. d.	Cost. 1911. £ s. d.
Bandages, Grey	1128 gross.	1107 gross.	523 6 8	545 15 11
„ Crepe	24 doz.	21 doz.	7 16 0	7 1 0
„ White	776 gross.	694 gross.	501 6 10	462 13 7
Bandage Cloth	19,884 yds.	18,852 yds.	130 12 8	119 2 1
Cellulose Wadding	2 cwt.	252 lbs.	5 14 8	4 4 2
Felt	17 lbs.	13 „	5 1 2	3 4 7
„ Poroplastic	9½ „	18 „	2 2 9	4 5 3
Gauze, Double Cyanide	44,412 yds.	47,604 yds.	122 15 9	138 1 11
„ Grey	38,964 „	36,924 „	92 11 6	82 3 4
„ Iodoform	6,804 „	8,796 „	24 1 11	34 16 4
„ Ribbon	28½ doz.	61 doz.	9 11 9	19 10 6
Holland, Brown	—	24 rolls.	—	44 3 3
Lint	120¼ cwt.	126 cwt.	677 12 0	636 16 0
„ Boric	38 „	33 „	165 4 0	143 17 6
Moss, Compressed	91½ sheets.	240 sheets.	4 11 6	6 7 0
Strapping, Rubber	43 doz.	32 doz.	47 11 7	37 19 6
Tissue, Wool and Gauze	5 cwt.	5 cwt.	20 9 6	20 3 8
„ Gutta Percha	542½ lbs.	563 lbs.	94 18 10	106 16 10
Tow	10 cwt.	8 cwt.	12 10 0	8 6 0
„ Carbolized	63 lbs.	—	1 6 10	—
Wool, Absorbent	88 cwt.	106 cwt.	404 11 0	399 16 0
„ Grey	33 „	38 „	63 19 10	73 16 0
„ Sal Alembroth	—	2 „	—	7 18 8
Total			£2,917 16 9	£2,906 19 1

SERA.

	Quantity Bought. 1912.	Quantity Bought. 1911.	Cost. 1912. £ s. d.	Cost. 1911. £ s. d.
Anti-Anthrax Serum	None used.	240 ccs.	—	3 17 6
„ Colon Bacillus	375 ccs.	360 „	4 7 6	8 15 7
„ Diphtheria	57,000 units.	4,080 „	50 2 0	75 15 0
„ Meningococcus	230 ccs.	110 „	1 18 3	1 10 3
„ Pneumococcus	110 „	None used.	1 19 6	—
„ Streptococcus	3,960 „	2,580 ccs.	29 12 3	40 5 0
„ Tetanic	720 „	—	7 12 0	9 17 6
„ Thyreoidin (Mœbius)	360 „	None used.	6 4 1	—
Normal Horse Serum	780 „	1,510 ccs.	3 5 11	5 12 9
Total			£105 1 6	£145 13 7

SPECIAL ITEMS.

The following figures are given to show the large amount spent on a few items:—

	Quantity Bought. 1912.	Quantity Bought. 1911.	Cost. 1912. £ s. d.	Cost. 1911. £ s. d.
Bismuth Salts	393 lbs.	336 lbs.	161 18 1	137 11 0
Camphor	453 lbs.	268 lbs.	36 16 3	21 15 6
Cod Liver Oil	250 gals.	240 gals.	44 18 4	63 17 4
Glycerine	34 cwt.	35 cwt.	156 7 0	171 12 6
Honey	23 cwt.	41 cwt.	32 8 3	54 7 7
Lard	16 cwt.	14 cwt.	42 14 0	39 4 0
Malt Extract	161 cwt.	190 cwt.	168 0 0	203 17 6
Olive Oil	243 gals.	270 gals.	59 3 3	77 3 1
Potassium Iodide	336 lbs.	364 lbs.	133 15 2	135 2 4
Spirit, Methylated	1,760 gals.	1,600 gals.	184 13 4	153 6 8
Spirit, Rectified	150 gals.	200 gals.	195 4 2	260 4 2
Sugar	75 cwt.	89 cwt.	75 15 0	72 3 0
Total			£1,291 12 10	£1,390 4 8

PHARMACEUTICAL LABORATORY.

The work of this section has included the following:—

	1912.	1911.
Collodions	6 gals.	11¾ gals.
Confections	5 2/3 cwt.	1 cwt. 11 lbs.
Dentifrices	1½ cwt.	2 cwt. 3 lbs.
Lotions	5,000 gals.	5,000 gals.
Liniments	290 gals.	300 gals.
Mixtures	11,150 gals.	9,876 gals.
Ointments	47½ cwt.	59 cwt.
Plasters	4,505 yards.	4,646 yards.
Syrups	950 gals.	1,299 gals.
Tablets (compressed)	18 cwt.	9 cwt.
Tinctures and Liquid Extracts	245 gals.	314 gals.
Soda Water	32,332 syphons	32,343 syphons
Ether Soap	264 gals.	184 gals.

Among the articles that have increased in price during the past year the following may be mentioned:—Opium, Morphine and its derivatives, Acetomorphine and Codeine. The increased cost has been about 100 per cent., which represents an increased expenditure of £36 on these.

Cane sugar has increased in cost by 5/- per cwt., and although about half a ton less has been used, the cost has been £7 more. Milk sugar has increased in price from 47/6 to 75/- per cwt.

The following articles have come into more extended use during the past year:—Medinal, the Sodium compound of Veronal, 38 ounces have been used at a cost of £6 19s. 8d. 200 tubes of Salvarsan and Neo-Salvarsan have been used at a cost of £70. Liquid Paraffin, 15 cwt. costing £30 were used in 1911, while 2 tons, for which £73 was paid, were used in 1912. Pituitary Extract to the value of £59 was used in 1912 as against £43 worth in 1911.

(Signed) HORACE FINNEMORE,
February 6th, 1913. Pharmacist to the Hospital.

Pupils' Physical Society.

A Pathological Meeting of the Society was held in the Wills Library on Wednesday, February 12th, at 8 p.m. Mr. H. L. James was in the chair, and 35 members were present.

The following specimens were shown:—Sarcoma of duodenum (Mr. Heaton); adenoma of thyroid (Mr. Joly); adenoma of thyroid (Mr. Todd); specimens from a case of acute leukæmia (Mr. Harkness); cerebral abscess (Mr. Morgan); tubal mole and tubal abortion (Mr. Savage); actinomycosis of liver (Mr. Minns); carcinoma of stomach (Mr. Todd).

The following members contributed to the discussion: The President, Messrs. Miller, Robinson, Todd, Mutch, Richards, Hunt, Ryle, Joly, Fawcus, Savage, Morgan, Liebson, Drs. Mann and Maxted, and the Jun. Hon. Sec.

London Bridge and the Borough in the Eighteenth Century.

(*Continued from page 70, new vol.*)

XVIII.

CONCLUSION.

"*No, Sir, when a man is tired of London he is tired of life.*" DR. JOHNSON.

OUR perambulation of the hospital district is, at length, completed, and in the nine months that have elapsed since its commencement several events in direct relation to our subject have taken place. The midsummer rent of St. Olave's Grammar School has been paid with its red rose; Doggett's race for Coat and Badge has been rowed; a Court of Pye Powder has been held during the celebration of Barnet Fair; the niches of Bishop Fox's altar-screen have been filled with statuary, and William Shakespeare has joined Lionel Lockyer among the exhibits of St. Saviour's. And, as we learned from a newspaper a few weeks ago, "one of the members of a firm established in Southwark for close on 200 years has made public the fact that, as their premises are in the Liberty of the Clink, he is exempt from giving jury service in respect of them; dwellers within the Liberty being qualified in an old Act of Parliament as '*unclean persons, unfit to associate with honest men.*'"

On the other hand, several of our "illustrations" meantime have been threatened or have actually disappeared. St. Martin's-le-Grand has become a dead-letter; Bridewell is condemned; Southwark Bridge is suspended for drastic alteration; and our old operating theatre has been eradicated. Had it been foreseen that any words of ours would entail such consequences, other institutions might have been named.

To write some eighteen essays on Southwark and Bermondsey with hardly a reference to Charles Dickens and his works was not an easy task. "King Charles's head" could scarcely have been refused admittance to this Memorial if it had not already been disposed of, to a great extent, in the centenary article a year ago. And whatever the shortcomings to be discovered in the present series, it may be conceded that to have introduced both Francis, Lord Verulam, and "Wilm. Shaxpr" within the limits of the same chapter and without a conflict, is a definite achievement.

The general title chosen at the outset became unsuitable after the scope of the series had been expanded to include history of more than a single century, but it was retained for reasons with which the writer was not concerned. An apology is likewise due for the several errors of omission and commission noted below; generally they are the result of pressure of time and space in preparing the articles for publication, although in some cases it has been necessary to decide between conflicting evidence from different authorities.

Nonsuch House did not make its appearance on London Bridge before the reign of Elizabeth. The Bridge House occupied a situation, correctly stated in Chapter VII., to the *east* of St. Olave's Church. The name of the donor of the statue of Edward VI. was Charles Joye, and the alteration of the front of Guy's was begun in 1774, not 1744.

In the case of the church at Horslydown, for "rebuilders" read "builders." There was no church there until after Guy's day, and St. John's was built "in the year of the Comet," as the odd-looking meteor, that serves as a weather-vane, implies.

St. Bartholomew's Hospital goes one better than its competitors in the classic orders of architecture, for its façade displays both Ionic pilasters and Corinthian columns.

In the list of bye-ways, the Queen's Head Inn, Nag's Head Alley, Maypole Alley and Three Crown Alley should all have been retained in Roman type, since these names are still represented in the Borough.

Pepper Alley, which Dr. Johnson said was as healthy as Salisbury Plain and *much happier*, gave its name to some well-known riverside stairs where the present bridge joins the shore. The old White Hart with its galleries survived until 1889. Southwark Street was only made in 1860; but Newcomen Street dates from 1760, and Union Street, opposite, from 1768. Hogarth's illustration to "The Beggar's Opera"—the play that "made Gay (the author) rich, and Rich (the manager) gay"—probably represents a scene in Old Bailey rather than in the Mint.

With regard to Old Bethlem in Moorfields, it was once said that the design of the building was taken from that of the Tuilleries, and that "Louis XIV. was so much offended that his palace should be made a model for an hospital that in revenge he ordered a plan of St. James's to be taken for offices of a very inferior nature!"

We might have mentioned, in speaking of Brass Crosby, Esq., that his colleague, Jack Wilkes, was Lord Mayor in 1772, and that he also has his obelisk, but in Ludgate Circus.

In Rotherhithe once lived Captain Coram, founder of the Foundling. There, also, died and was buried in the churchyard, Prince Lee-boo of the Pelew Islands, in 1784. The statue in Trinity Square may possibly have come from the older Trinity House at Deptford, before the removal in 1798 to Tower Hill; the fact that the posterior aspect of the statue is unsculptured make it highly probable that it once adorned a niche on the front of a building.

Aubrey's statement that the Loke was at one time a possession of St. Thomas's is evidently mistaken; the historian of the latter hospital is quite definite in ascribing the ownership to St. Bartholomew's.

Thanks to Sir Sidney Colvin's "Life," we are enabled to speak more fully of John Keats's residence near Guy's. At his entry at the Hospital in 1814, and for the first winter and spring, he lodged at 8, Dean Street. Afterwards, acting on the advice of Sir Astley Cooper, he moved to a room above a tallow-chandler's shop in St. Thomas's Street. It was in these rooms late one night on his return from spending the evening with Cowden Clark, in Clerkenwell, that he wrote the wonderful sonnet "On First Looking into Chapman's Homer." On July 26th, 1815, he passed with credit as Licentiate of the Apothecaries' Hall, and in the following spring was appointed dresser to Mr. Lucas of Guy's, leaving the Borough shortly after to join his brothers in lodgings in the Poultry.

Thomas Doggett instituted his watermen's race from the Old Swan by London Bridge to the Swan at Chelsea in 1716, to commemorate the accession of the House of Brunswick. He was patentee of Drury Lane Theatre until 1712. Steele describes his "comick manner" and "arch leer" in the *Tatler* of July 11th, 1710. He died on September 22nd, 1721, and was buried at Eltham.

The "clock-tower resembling a market-cross of Gothic design with a canopied niche for the statue of the great Duke of Wellington" was erected in the Borough High Street in 1854, but proving an obstruction was removed to Swanage, where are the entire front of the old Mercer's Hall from Cheapside and numerous other London remains. Sir Francis Burnand, in his "Records and Reminiscences," speaks of "a whole regiment . . . of iron posts looking like cannon stuck on end, muzzles upwards, with a tight fit of half a cannon-ball squeezing itself out at the top . . . at Swanage, near Bournemouth, where they were planted by the late Mr. Burt, Sheriff of the City of London, ironmaster . . . who in fulfilment of a contract with the City had become possessed of this store of queer old London relics." Perhaps there are some of the Clink posts amongst those from St. Anne's, Soho, and St. Martin's-in-the-Fields.

When old London Bridge was removed, "the stone proved finely seasoned material, and a portion of it was purchased by Alderman Harmer and used in building his seat, Ingres Abbey near Greenhithe."

At the alteration of the roadway in 1833, all the front quadrangle of St. Thomas's was removed, including the buildings on the eastern side with the stonework façade, as well as the whole of Frederick's and Guy's wards.

Some injustice has been done to Bartolozzi in the statement on page 462. The topheavy appearance of the front and the poor drawing of the rusticated basement are both exhibited by the marble original. As for Guy's coiffure, whether Bacon intended to represent the natural hair crimped into symmetrical rolls over the ears, or a short wig, neither of these fashions was generally adopted until well after Guy's day. For purposes of comparison, it may be worth while to study the very similar figure of Pitt, in the Guildhall, which illustrates another mannerism of Bacon's in the front of the right shoe projecting beyond the pedestal. Other notable examples of his work in London are the bronze statue of George III. and the two groups of statuary with the colossal figure of the Thames in the fountain in the courtyard of Somerset House.

Pennant, in approaching Guy's monument, was quoting from Pope :—

"*When Hopkins dies a thousand lights attend*
The wretch who, living, spared a candle's end;
Shouldering God's Altar *a vile image stands,*
Belies his features, nay, extends his hands;
That live-long wig which Gorgon's self might own,
Eternal buckle takes in Parian stone."

Pope's own note on these lines runs thus :—"Ridicule the wretched taste of carving large periwigs on bustos of which there are several vile examples among the tombs of Westminster and elsewhere."

It seems evident that Pennant had "Vulture" Hopkins in his mind when making this slighting reference to Guy's monument. Hopkins died in his house in Broad Street in 1732, leaving £300,000, of which several thousands were spent on an imposing funeral. As for the story which couples his name with Guy's, it seems sufficient ground for dismissing it as a fabrication when we find the same story related of another person in another country. It is said of "Dumoulin, or rather Molin, physician, that a great economist, not to say a miser, having heard that Dumoulin far surpassed him in saving-knowledge, waited on him one winter evening." . . . "Is that all?" replied Dumoulin. "Be seated, sir"; and in saying so, he extinguished the lamp. "There is no occasion for light to show us how to talk; it only produces inattention."

Another instance of a famous anecdote doing service, *mutato nomine*, on another occasion, occurs in Bransby Cooper's life of his uncle. It is there told of Dr. Fordyce, the botanist and physician to St. Thomas's Hospital, who was, in the opinion of Sir Astley, "a coarse man, a bad lecturer, got drunk every evening, and, Mr. Cline said, was not over-careful about truth." The story, which Bransby relates on the authority of Mr. Whitfield, the late apothecary of St. Thomas's, follows the earlier history of Dr. Mead, with the single exception that the heroine is no longer a duchess but "a lady of fortune and influence."

Dr. Lettsom, whose opinion of Akenside has been quoted is best remembered by the satirical jingle,

When folks is sick they comes to I,
I physicks, bleeds and sweats 'em;
And if in spite of that they die—
What's that to I; I lets 'em."

Apart from that, however, he is known jointly with Dr. Fothergill, as the founder, in 1773, of the Medical Society of London.

The date of the temporary estrangement between the Borough Hospitals, from 1760 to 1768, has already been corrected.

By an error in transcription, "the Cardinal" is given the credit, due to Bishop Waynflete (in occupation at Winchester House in 1473), for building the stone bridge in Bermondsey Street, and from confronting Wat Tyler.

Seymour was the friend (not Strype), who supplied the details on page 44 of the boundaries of the Clink Liberty.

Although Southwark Bridge obtained its Act of Parliament in 1811, building was not begun until three years later, and was only completed in 1819. The original Blackfriars Bridge was begun in 1760; and was replaced by the present structure in 1867.

Whilst Old London Bridge still existed the nineteen stone piers so held back the great volume of water that the tide ran like a mill-race through the arches, and timid passengers thought it more prudent to leave their boat and rejoin it below bridge rather than shoot the rapids. When the old bridge had been removed the force of the stream no longer held back as by a weir, was so increased that the foundations of Westminster Bridge, originally built in 1739, were shaken, and it was first closed to traffic in 1846, and then rebuilt 1855–1862.

The various sources from which the material for these articles has been drawn, have generally been cited along with the quotation. Of the London historians, Stowe (1603), his editor, Strype (1722 and 1755), Seymour (1733), Maitland (1739), Northouck (1773), Harrison (1777), and Pennant (1793), have all been laid under contribution.

Aubrey's Surrey (1719), The Natural History and Views of London, edited by C. F. Partington (1835) and John Timbs's Curiosities of London (1855) have provided a large amount of miscellaneous information, and a few notes have been borrowed from Mr. Whitten's edition of "A Book for a Rainy Day," by J. T. Smith, and from "Old London Burial Grounds," by Mrs. Basil Holmes (1896).

Of the works devoted exclusively to South London the following have been consulted:—Concanen and Morgan's History (1795); "Southwark and its Story" (1881), by Mrs. Charlotte Boger; "Lectures on the History of Southwark" (1863), by James Robertson, of 5, Bankside; Sir Walter Besant's "South London" (as well as his "London," and "Survey"); some historical notes, written by Sir Lawrence Gomme for a pamphlet on the "Opening of the New Southern Approach to the Tower Bridge" (1902); and an article on the Borough Inns, by Thomas Wright, in "Once a Week," 1867. But by far the greatest debt is to the works of Dr. Rendle (1811–1893) the "Southwark Antiquary." But for "Old Southwark and its People," 1878, very many interesting details would have been missing from the present series. These extensive borrowings have been made with the less compunction since Dr. William Rendle was himself a Guy's man. We have been unwilling, however, to avail ourselves of this excuse to draw too freely from another fascinating book of his, written in collaboration with Philip Norman, Esq., F.S.A., "The Inns of Old Southwark," since this work is more generally accessible than the former.

The hospital articles have been based upon Rendle's investigations into the early history of St. Thomas's in the book cited above; Dr. Benjamin Golding's "Historical Account of St. Thomas's Hospital" (1819); the second edition of "Guy's Will" with the Governors' "Advertisement" (1732); and two odd volumes of "Professional Anecdotes, or Ana of Medical Literature" (1823). The invaluable Biographical History of Guy's, by Wilks and Bettany has been used, of course, although we have endeavoured to refrain from drawing upon it more than was necessary to shape the material from other sources into a connected narrative. We venture to hope that the result shows the possibility of supplementing Wilks and Bettany's store of information by a small amount of desultory reading; and that readers of the Gazette will add to that store by communicating any further allusions to hospital matters they may discover.

Special thanks are tendered to Dr. A. Shillitoe for sending the Gazette his most interesting paper on the history of the Lock Hospital and its predecessors in Kingsland Road and Kent Street.

Despite the authorities just quoted, information would be welcomed on several points; the origin of the statue in Trinity Square; the fate of the two statues of patients from the piers of Guy's gateway at old St. Thomas's; the locality of "the Isle of Ducks" in St. Olave's parish; and the derivation of the name of Shad Thames, of which the local explanation that the fish so-called is landed there is scarcely satisfactory. Finally, who were (1) Hickman and (2) Sparrick?

To conclude, it may be mentioned that the purpose of these articles has been to stimulate an interest in the history of the locality, and, in particular, of the Hospital itself, in order to smoothe the way to the creation of a small museum for the preservation of the antiquities of Guy's. Londoners are proverbially indifferent to the attractions of their native city, but there are others who are not so unconcerned, and it would be well if such a plan could be carried to a successful conclusion, were it only for the benefit of the New Zealander of Macaulay's prophetic vision who, in the scanty leisure afforded by his "Rugger" and his house-appointment, might care to take his stand by our own particular fragment of London Bridge to construct a mental picture of the London that is dead and gone.

R. M. WINGENT.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the Gazette *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette." Guy's Hospital, London, S.E.*

Success in General Practice.

Everybody knows the painter, Gainsborough's, reply to the young artist who asked him what he mixed his colours with: "Brains, sir, brains," said the great man.

At an opening night of the Physical Society, I heard Sir Samuel Wilks put our case differently. "Gentlemen," he said, "ours is not the profession that the fool of the family is put into."

I think we may take it as certain that a good brain is a chief factor in success in our profession. It will be as well, I think, if I now briefly state what I understand success to mean. Certainly it is very unlikely to mean the amassing of a fortune; few general practitioners save much money. "Ours is not a money-making profession," Sir Samuel Wilks used to say. Also, it will not mean social success as a rule, or luxurious living.

The successful doctor will have to work as hard as any man, he will have many disappointments and he will experience some ingratitude. and much of his work will be very ill-paid. But apart from such as these, the drawbacks are not very serious. Success means a comfortable income, and the honour and grateful affection of numbers of people in all conditions of life. It will be a man's own fault if he makes many enemies, and his friends he will never know the number of. Our work is a continual benefit to mankind, and now we have opening out before us the great movement for the improvement of the condition of the poor and helpless. If we would be truly successful we must take our part in that

I think the family doctor ought to be married. When he has made the plunge, he will find the difference it makes with mothers and daughters, and fathers, too. Besides a wife will teach him so much he did not know.

We do not generally take advice about choosing our wives; often we have very little choice in the matter, but there is no harm in my suggesting to my young and ardent friends that a certain amount of diagnostic skill may well be exercised even in this case. I remember years ago when I was talking on this subject with a very well-known Guy's man, he said: "Well, dear boy, she will always be there, you know; she'll be there when you want her, and she'll be there when you don't want her." So I say, marry, but marry with caution.

The last thing I would advise a man to do is to marry for money, but I might say, "Don't let money frighten you, if you love the lady."

It is very important that the young doctor should quickly establish good relations with his fellow practitioners. He must call on them, and although he will find some of us not very pleased to see him, yet there will be others who will offer him the hand of friendship. Some doctors do well for a time who are at variance with all their professional brethren, and I have known large practices built up by improper and unprofessional conduct. But a day of reckoning comes to a man of this sort, when he makes a bad mistake and it depends on the forbearance of an offended rival whether he gets out of his trouble or not.

What line should the young doctor take in the work of his practice? I have no doubt that for the family doctor midwifery remains the most important work he will do. If he has a middle and working-class practice he will get plenty of it, and if he likes it and can acquire the necessary manual dexterity he may make himself as proficient as any London specialist. I know general practitioners who deal successfully with the most serious midwifery cases, as part of their everyday routine work. I look upon midwifery as much the finest and most responsible work the general practitioner has to do.

Next in importance to midwifery I place children's diseases and child management. A great deal of the difficulty of doctoring children is due to the general ignorance of the working of the child-mind, of their limited knowledge and understanding, and of their extraordinary powers of imagination. I recommend to all family doctors a course of reading of the best of the books on child psychology and child training.

What about surgery, that many of our young doctors are so keen about? I am sure it is desirable from the patient's point of view that in every country town there should be one or two doctors who have sufficient skill to deal with the ordinary surgical emergencies, and if the young doctor has a hospital appointment and can deal with these cases satisfactorily he will find that his successes will spread his fame and give him a position like nothing else.

But surgery takes up a great deal of time, very little money is made by it in general practice, and success will cause some jealousy amongst the older men.

There are now many general practitioners who do their own bacteriological work, and this gives them a great advantage, an advantage which is likely to increase as time goes on. So I advise any man who has a taste for it and is willing to devote to it a good deal of his leisure, to start a bacteriological laboratory. If his work can be relied on, it will not be long before he will have the older men coming to him with their difficulties and paying for his help.

I feel sure we do not give sufficient attention to therapeutics. Many doctors, especially those who write prescriptions, seem to treat their patients entirely with new drugs. Sir Samuel Wilks used to say 'You will find pages of advertisements in the medical papers extolling new remedies; if you must use them, use them as they come out, for as a rule their virtue depends on their novelty; in six months they are forgotten."

We have a score or two of drugs, some old, some new, each of which used properly, at the proper time, will work a miracle. We ought to know all there is to know about these sovereign remedies and add to the list as time goes on.

If a doctor is to continue the successful working of a large practice he must not forget his own health; recreation is as necessary to him as to any other hard worker. There is no sense in killing yourself to keep yourself. Many kinds of men succeed as doctors: competent men and incompetent, honest men and quacks, men who are popular with the rest of us and men who are not, but in every case where a notable success has been achieved it will be found that the successful man has won the confidence of his patients and that they speak well of him. J. H. G.

Guy's Hospital Dental Society.

On Saturday, February 15th, a dental clinical gathering was held in the New Buildings. In spite of appalling weather well over a hundred past and present Guy's men and friends were present, and seemed greatly to appreciate the trouble which the staff had taken to make the meeting a success. Although the clinical cases in the conservation room proved to be the chief source of attraction, the other parts of the building were not neglected.

In the metallurgical laboratory where Mr. Pearce was demonstrating the properties of various amalgams there was always a group of interested spectators. The exhibition of mechanical work in the pupils' laboratory did not fail to please its clique of critics and admirers, while the students' laboratory was literally packed between the hours of four and five.

The clinical cases had been selected with great care, and fervent orthodontists and pyorrhœa enthusiasts had nothing to grumble at on the score that they had been forgotten. The surgical cases were very varied and of exceptional interest. Nearly everything in the nature of rarer dental lesions was on view. In another section of the building, exhibits of recent museum specimens of microscopical sections, and of vaccine preparations, helped to keep even the most casual observer fully interested, while Mr. Parfitt's inlay work was a revelation to many. The meeting, which is to be an annual event in the Hospital year, bids fair to become increasingly popular as time goes on. The originators of the scheme deserve to be heartily congratulated on the success of their endeavours.

The Annual Dinner took place the same evening at the Trocadero Restauraunt. Two hundred and twelve members of the Society attended. Mr. Ernest B. Dowsett was in the chair, and received an ovation. Mr. Hughes was the guest of the evening, while many other guests of note, both in the Medical and Dental world, were present. The usual toasts were proposed and responded to, interspersed by songs and recitations, which contributed greatly to the enjoyment of the evening.

Guy's Hospital Debating Society.

A debate, the subject of which was "That in the opinion of this House war is necessary for the settling of international disputes," was held in the Club Smoking-room on Ladies' Night, February 6th. Some seventy visitors and members were present. Dr. Shaw occupied the chair.

The debate was a success, though the discussion, considered generally, was not good, for although individual speeches were really excellent, yet speakers would not keep to the point. They spoke repeatedly of the horrors of war, of war in the future, of the value of education, of the dawn of a new era of peace. The little word "is" was sadly neglected, while many speakers never got beyond the first two words of the motion, and quite forgot that "necessary," "settling," or "disputes" had any connection with the subject under discussion. With them it was all war; whether red, lurid, horrible, or glorious and stimulating, depended on the views they held.

Other speakers revelled in illogical arguments, such as evil is unnecessary, war is an evil, therefore war is unnecessary; war is necessary, for without war there would be no peace. Others, again, delighted in paradox of the following nature:—"Gentlemen, I long for the day when men and women shall fight shoulder to shoulder to the last drop in favour of peace." Very few speakers were at all humorous, but spoke for the most part as though they were making history. Mr. Pedley, however, that delightfully unorthodox speaker, kept the house well amused. His propensity for slang, his groping after the right word, and a certain jerkiness in delivery, are more than entertaining.

Mr. Ormond opened the debate. Unlike the majority of speakers, he kept more or less to the point. He traced the causes of various recent wars, proving, to his own satisfaction at least, that no amount of arbitration could have averted actual bloodshed, for, indeed, had not arbitration been tried in every case for months before the outbreak of hostilities? Nothing short of war could have induced the Boers to redress the grievances of Englishmen; nothing short of breaking the power of the Turk could bring about a settlement of the Balkan question. He contended that in certain cases war had been, and was at the present time, inevitable. He brushed on one side all the contentions of Norman Angell as being quite beside the point. It mattered little whether war was profitable or the reverse. At present arbitration was no real substitute for war.

Mr. J. A. Ryle, commenting on the rashness of the proposer in attempting to uphold an absurdity by maintaining that war was necessary for the settling of international disputes at a period in history in which

more disputes had been settled by arbitration than in any other, proceeded to appeal to the common sense as opposed to the emotions of the assembly. Refusing to have resort to moral, humane, or religious arguments, he confined himself almost solely to the economic aspect of the question, and based his argument that war was not necessary at all, principally on the unchallenged doctrines of Norman Angell. He pointed out that wars were waged, and the difficulties of peace reformers arose as the result of an assumption that war brought some benefit to the conquering party. This assumption had been proved to be entirely erroneous. No territorial or financial advantage could be gained under present conditions. The fallacies of the proposer's instancing of the Balkan War as a failure of arbitration were obvious. In the first place there had not been a sudden outbreak; war had been waged in the Balkans for 400 years. In the second place, the Powers were actually responsible for the war, since they had continued to countenance the atrocities of the Turk when it had been in their power to end them. An effort to substitute reason for impulsive action would soon prove in practice that which had been demonstrated in incontrovertible theory—namely, that war was not necessary for the settling of international disputes.

Mr. POULTON, who seconded the proposition, was not up to his usual form, and seemed to see too much of both sides of the question. He upheld the value of the lessons of war, endeavoured to prove that war had been necessary in the past, and that the conditions which held good then often hold good to-day.

Mr. FAWCUS contended that as education advanced so did resort to war decrease. He instanced the war with the American colonies, a hundred years ago, which would have been impossible to-day. The mother country would never dream of trying to coerce the colonies now.

A lady speaker who continued the discussion made a very excellent speech. Supporting the motion on valiant ground she proceeded to prove that war would always be resorted to by those nations such as the Poles, who had everything to gain and nothing to lose—whose present condition as a nation could never be worse, whatever the fortunes of war.

Mr. NEVILLE COX made a long speech on suffrage syndicalism, practical socialism, and the State.

Mr. SANDISON, continuing in the same strain, made a very eloquent speech, not altogether devoid of that idealistic egotism which seems to characterise the utterances of all fervent democrats

Mr. LAYTON rose to carry on the discussion, speaking very quietly in spite of the sneers at militarism which had been hurled at his head by previous speakers. He contended that we are all ruled by force, and that if individuals do not fight, it is because they can appeal to law, which is equivalent to an appeal to arms on the part of nations. He rebuked the opposition for their conceit, their cocksureness, and their sordidness, and proceeded to turn the tables on the peace-at-any-price group.

Many members and friends subsequently spoke. One lady quarrelled with the motion, contending that disputes were never settled. Mr. GATLEY beat the big drum. Mr. HEATON summed up the position for the proposition by wisely saying that force is the only logical appeal of nations, while Mr. PEDLEY put everyone in a good humour.

Mr. RYLE and Mr. ORMOND replied respectively, and the motion was put to the vote at 10.45, and was carried by 36 votes to 31.

A vote of thanks to the Chairman terminated the proceedings, and the House adjourned for refreshments.

Practical Surgical Hints.

1. Tuberculous Joints.

It is an absolute rule that every tuberculous joint must be immobilised for one year after the *last* manifestation of active disease. And it must be genuine immobilisation; a wooden splint, bandaged on once a fortnight, is of no use.

Whenever possible, fix the joint above and the joint below; in the case of the hip, this implies the fixation of the lower part of the spine by means of a "spica."

Pain, during weight extension, is much more probably due to insufficient than to excessive weighting. The inexperienced are often apt to remove weights at night if a child is restless; very often an extra pound or so will produce sleep when aspirin is useless. The effect of the weight is to separate the inflamed surfaces of bone and cartilage.

Remember that the only really effective agent in curing a tuberculous joint is fixation; the worse the joint, the greater is the need for it, and if it is conscientiously carried out, a good prognosis can be given in all cases, in youth.

When in doubt as to whether a joint is affected with early tubercle or not, do not fix it with a splint, for the symptoms will improve for the time being, whatever the cause of the illness. Rather let the child run about for a week, and then re-examine; the diagnosis will then be obvious.

Parents are always afraid that the prolonged use of a splint will result in the child becoming very weak; this is not true. Generally, the relief from pain and sleeplessness is followed in a short time by improvement in appetite and appearance.

When putting up a leg in plaster, the knee must be *absolutely* straight; if it be flexed, even to the slightest degree, the hamstring muscles can exert a leverage, and his, assisted by the calf muscles, results in slow, steady ncrease of the flexion. As a rule, after the leg has been straightened by means of weight as far as possible, it is necessary to support the heel on a cushion, and then lay sandbags across the knee for a few days. Even then, an anæsthetic is often necessary to enable the surgeon to apply the plaster in perfect position.

A. H. TODD.

Books and Journals recently added to the Wills Library.

BY PURCHASE.

American Journal of the Medical Sciences. From Vol. 131, 1906, when it was previously discontinued.

Burchard's Text-book of Dental Pathology and Therapeutics. 4th edition, 1912.

Bythell and Barclay's X-ray Diagnosis and Treatment, 1912.

Choyce's System of Surgery. Vols. 1 and 2, 1912.

Coleman and Hilliard's Anæsthetics in Dental Surgery, 1912.

Colyer's Dental Surgery, 1910. Two extra copies.

Cushing's Pituitary Body and its Disorders: Clinical Studies produced by Disorders of the Hypophysis Cerebri, 1912.

Dixon's Manual of Human Osteology, 1912.

Dixon's Manual of Pharmacology. 3rd edition, 1912.

Eden's Manual of Gynæcology, 1911. Extra copy.

Eden's Manual of Midwifery. 3rd edition, 1911. Extra copy.

Fischer's Local Anæsthesia in Dentistry, 1912.

Gee's Medical Lectures and Aphorisms. 2nd edition, 1907.

Grunbaum's Essentials of Morbid Histology, 1912.

*Guerini's History of Dentistry, 1909.

Hewitt's Anæsthetics and their Administration. 4th edition, 1912.

Hewlett's Pathology, General and Special. 3rd edition, 1912.

Howell's Text-book of Physiology. 4th edition, 1912.

Journal of the American Medical Association. Vol. 59, 1912, and in continuation.

Keith's Human Embryology and Morphology. 3rd edition, 1913.

Kidd's Urinary Surgery, 1910.

Lischer's Principles and Methods of Orthodontics, 1912.

*Mall and Keibel's Manual of Human Embryology. Two vols., 1910—1912.

Morris and McMurrich's Human Anatomy. 4th edition, 1907.

Pickerill's Prevention of Dental Caries and Oral Sepsis, 1912.

Powell and Hartley's Diseases of the Lungs and Pleuræ, 1911.

Schafer's Text-book of Microscopic Anatomy, 1912.

Starling's Principles of Human Physiology, 1912.

Taylor's Principles and Practice of Medical Jurisprudence. 6th edition, 2 vols, 1910.

Wade's Organic Chemistry, 1911.

Waring's Manual of Operative Surgery. 4th edition, 1912.

* For Davies-Colley Memorial.

PRESENTED.

Addison's Die Erkrankungen der Nebennieren und ihre Folgen, 1855. German translation by Dr. Erich Ebstein. By the Translator.

Bagster's Comprehensive Bible, 1827. Formerly the property of the late Sir Samuel Wilks, Bart. By Miss Agnes Martelli, of Hampstead.

Butlin's Three Lectures on Unicellula Cancri, 1912. By Lady Butlin.

Calendar of the Royal College of Surgeons, 1912. By the Council of the R.C.S.

Cowper's Myotomia Reformata; or an Anatomical Treatise on the Muscles, etc., 1724. By Dr. Daniel Forty, of Wotton-under-Edge.

Flexner's Medical Education in Europe, 1912. By the Publishers.

Gilford's Disorders of Post-natal Growth and Development, 1911. By Mr. Hastings Gilford.

Goodhart's Passing of Morbid Anatomy, 1912. Two copies. By Sir James F. Goodhart, Bart.

Journal of Physiology. As published. By Dr. Hertz.

Keats's Complete Poetical Works. Edited by H. Buxton Forman, C.B., 1910. By Mr. Wm. Wale.

Lane's Cleft Palate and Hare Lip, 1908. By Mr. W. A. Lane.

Lane's Fractures, Cleft Palate, etc. 2nd edition, 1900. By Mr. W. A. Lane.

Lane's Operative Treatment of Fractures, 1905. By Mr. W. A. Lane.

Liston and Williams's A Streptothrix isolated from the Spleen of a Leper, 1912. By the Government of India.

Loxton's Medical Directory of Australia, etc., 1910. By the Publisher.

Newcombe's Catalogue of the Periodical Publications. . . . in University College, 1912. By R. W. Chambers, M.A.

Osler's Principles and Practice of Medicine. 8th edition. By Dr. H. C. Cameron.

Patton's Development of the Parasite of Indian Kala Azar, 1912. By the Government of India.

Practitioner. As published (commencing January, 1913). By Dr. Hertz.

Wale's What Great Men have said about Great Men. A Dictionary of Quotations, 1912. By Mr. W. Wale.

Wells's Dysentery in Hazaribagh Central Jail, January, 1910—March, 1911, 1912. By the Government of India.

Gazette Special Pathologist.

J. C., MARKET HARBOROUGH.—This is a simple multilocular ovarian adenoma. It is composed of a connective tissue stroma enclosing numbers of cavities lined by a long columnar epithelium. It is not a malignant growth. PATHOLOGIST.

Reviews, etc.

Books for review should be addressed to The Editor, Gazette Office, Guy's Hospital, S.E. Their price should in every case be stated.

Hoblyn's Dictionary of Terms used in Medicine and the Collateral Sciences. Fifteenth Edition, revised throughout, with numerous additions, by John A. P. Price, M.D., etc. (G. Bell & Sons).

The revision has spared such sentences as "the par vagum, nervi vagi, or eighth pair of nerves" (p. 606), and "Foramen of Winslow, an aperture situated behind the capsule of Glisson, first described by Winslow, and forming a communication between the large sac of the omentum and the cavity of the abdomen" (p. 303). We are still instructed as to the meaning of phlogiston, xanthocobaltia, xylopyrography, nihil album, hypnologist, epirrheology, didynamia, odellometer, untomool, photod, occhiombra, etc., etc. If you ignore the muscles of Wilson and Guthrie, then "Enquire Within"; here, also, you will find Wutzer's operation, but not Bassini's. A receipt for absinthe will meet your eye, and you will be told the truth about rossolio. The explanation of Zoology, with general sketch of classification, stands unaltered from the 1892 edition. Opsonins and hormones are indeed described, but salvarsan is not to be found. Altogether the Dictionary contains a great deal of curious information in brief. Perhaps the sixteenth edition will be "revised throughout, with numerous additions," and equally numerous excisions. The collateral sciences, including phrenology and palæochemistry, make too large a lump.

A Hand-Book of Physics. By W. H. White, M.A., B.Sc. (Messrs. Methuen & Co., Ltd.). Price 7s.6d. nett.

The author—an examiner in the University of London—has written this manual so as to meet the requirements of medical students.

With this object in view, the text has been illustrated with examples taken from papers set at the various Universities, and those paragraphs that are not essential for medical candidates to read have been marked with colons.

Prominence is given to that aspect of physics which pertains to Physiology, and it is a matter for regret that the sections which deal with elementary mechanics and colour vision are somewhat deficient in extent.

The teaching of the whole book is comprehensive and practical, and from an examination point of view, it is one of the best hand-books of Physics that we have come across in recent years.

A Manual of Immunity for Students and Practitioners. By Elizabeth T. Fraser, M.D. (Maclehouse & Sons, Glasgow). Price 5s. nett.

This small volume gives the history of the researches and improvements which have been made in the subject of Serum Therapy and Sero-diagnosis during the last twenty years.

It is compiled with a view to popularizing a subject usually regarded as "dry" and abstruse, and a glossary is appended to explain the strange terms which always accompany new sciences.

Though the views expressed are not always in accordance with those of other authorities, the fundamental principles underlying the process of Immunity are laid out in an able manner well calculated to engage the attention of the busy student and practitioner.

The Treatment of Infantile Paralysis. By Oskar Vulpius, M.D., Professor at the University of Heidelberg. Translated by A. H. Todd, M.B., B.S., B.Sc. (Lond.). (Baillière, Tindall and Cox). Price 10s. 6d. nett.

The increased prevalence of epidemic Encephalomyelitis during recent years, and the probability that this tendency to increase will be more apparent in the near future, is the principal reason why we welcome the issue in the English text of Professor Vulpius's important work.

The author is one of the leading authorities in the subject dealt with, and on his many years of experience is based this practical treatise, which is the most comprehensive and up-to-date account of the various aspects of the treatment of infantile paralysis we have available in English medical literature.

While the greater part of the work is devoted to the orthopædic treatment of the sequelæ of anterior poliomyelitis, a concise account of the acute stages, and contemporary views of its ætiology and pathology, are also included, and these chapters will be found of great value to those whose interest is concentrated more particularly on the medical aspect of the affection.

The illustrations are numerous, and especially do we welcome the means herein afforded to English surgeons of becoming better acquainted with the beautiful "Hessing" sheath-appliances, which are so popular on the Continent, and so little known in this country, and which represent an enormous advance on our ugly, cumbersome, and mechanically imperfect conglomerations of bars, buckles, and straps.

The thanks of the profession are due to Mr. Todd for the service he has rendered in introducing this work to his English colleagues, and we congratulate him on the excellence of his translation.

Aids to Gynæcology. By S. Jervoise-Adams, M.D. Fifth Edition. (Baillière, Tindall and Cox). Price 2s. 6d. cloth; 2s. paper.

The Students' Aid Series, of which this book is member, aims at providing summaries of the various subjects, omitting all but the important facts.

The present edition has been carefully revised, and should appeal to the men who desire to rehearse quickly, and memorize their text-book knowledge.

Vaccine Therapy. Its Theory and Practice. By R. W. Allen, M.D. Fourth Edition. (H. K. Lewis, London). Price 9s. nett.

The science of Vaccines has been receiving increased attention of late years, and general practitioners, who are prone to leave such matters in the hands of experts, will find in this volume a clear systematic account of modern researches into this subject.

Dr. Allen's connection with Guy's, and his recognized standing as a pathologist, are further reasons why his book should find a large circulation amongst past and present students.

The description of Opsonics, and their practical application, is given at great length, and in such a manner as to interest the reader, without being guilty of prosiness and complexity.

Amongst the other admirable sections are found important instructions in the preparation and administration of Vaccines, with notes on the indications for and against inoculation.

We sincerely congratulate the author on the masterly fashion in which he has dealt with his difficult subject, and on the success which attends his efforts to throw light on this modern therapeutical measure.

Manual of Medicines. By A. S. Woodwark, M.D. (Oxford Medical Publications). Price 10s. 6d., nett.

In writing this book the author seeks to supply a volume of reference for the busy practitioner, and a *vade mecum* for the student in the ward and out-patients.

That it fulfils a long-felt want is indisputable, and though it cannot replace or be substituted for the more exhaustive text-books, yet it should become of value as a "*ready-reckoner*" of medicine.

The orderly manner which characterizes the construction of the whole book, and the commendable fashion in which important details are emphasized, are matters for praise; and, with a little revision in the tabulation of causes, symptoms, and diagnosis, according to their relative importance, this manual should prove a valuable addition to that section of medical literature which aims at crystallizing the salient features of disease.

Pharmacy and Materia Medica for Nurses. By Horace Finnemore. (Published by H. H. G. Grattan, 17, The Borough, London Bridge, S.E.). Price 2s. 6d.

The author is to be congratulated on the production of a very excellent little work. We think we are right in saying that up to now no book of the sort has found general favour, and yet the need for it has been long apparent. For in recent years the teaching of nursing has become more and more reasonable, so that the nurse is now taught the why and wherefore of her instructions, and no longer follows them blindly—a great gain from the educational point of view; and nowhere more than in the administration of drugs is a grasp of the general outlines of the subject more needed. Even though her personal responsibility be limited, yet, sooner or later, there will arise occasions when a little personal knowledge will be very useful.

Mr. Finnemore has not made the mistake of offering too much knowledge for the average digestion. The book is clearly and attractively written, well printed, and well bound. We can suggest no added virtue to make it the nurses' standard work on the subject.

Rugby Football.

GUY'S v. CHARING CROSS.

The third round of the Cup Ties found the above opposed at Richmond on February 20th. The jerseys being very similar, Guy's played in white. Owing to a variety of reasons—short notice, injury, &c.—the team was not at full strength, and several men were called on from the 2nd XV. L. R. Broster had a damaged shoulder; W. S. Stranack could not get away; A. V. Moberly and H. P. Whitworth were also unable to turn out. It was a bitingly cold afternoon—all right for forwards and halves, but very nippy for the three-quarters and back. One is not at all surprised that passes were dropped. Charing Cross were unfortunate in getting Pailthorpe hurt so early in the game; only about fifteen minutes had elapsed before he got injured and had to go full-back. Guy's were 11 points to 3 at the end of the first half—1 goal, 1 penalty and 1 try to 1 penalty. After half-time, for about twenty minutes, Guy's scored very freely. Pritchard was the first to clear away and get a try. Then Curle got a chance which he made full use of, and went over in the corner. Rook scored 2 tries, and both were clever efforts. He had little room to work in either time, but headed off effectually, and made openings for himself. Medlock scored twice, his swerve on both occasions completely deceiving the opposition.

Remarks.—The game was not very interesting, and requires but little detailing. Medlock was in good form with the goal kicks. The final score reading: Guy's, 6 goals (one a penalty) and 3 tries (37 points) to Charing Cross, 1 penalty goal (3 points). Team:—

Guy's.—H. Millett (back); A. F. Rook, G. B. Pritchard, A. H. Harkness, C. L. Curle (three-quarters); J. E. Davies, C. H. Medlock (halves); C. L. Roberts, O. Parry-Jones, M. Tweed, A. L. Anthony, A. S. Liebson, A. B. Danby, C. G. Haynes E. F. Llarena (forwards).

As I write, the news comes to hand that London have beaten Bart.'s in the semi-final; so once again we shall have London up against us on March 6th, at Richmond. The forwards will do well to play with all the "devil" they can command, and not to kick too hard when near the line. It is useless to allow the opposing backs to clear with ease after a good movement. No good purpose is served by passing for the sake of doing so, but the centre three-quarters should give more chances to the

wingmen. The whole team have been tackling much better lately. Go low and go thoroughly is the plan. On the 6th, the whole side must get together at once, and go for the line with all the vim and determination possible. First blood is a great advantage. All men likely to be called on must keep as fit as possible. The Hospital looks to them to make sure that the Cup shall repose in the Smoking Room for yet another year.

GUY'S v. OLD LEYSIANS.

Every match since Christmas, at Honor Oak Park, has been played in mud, and the 15th of February was not an exception. Rain fell throughout the match, and the general conditions were most depressing. Guy's were somewhat sore after their Cup Tie of the previous Thursday, but they put up a good game, and eventually won by the margin of a marked goal and 1 try to 1 try. The Old Boys brought down a good side, but they missed C. Pinkham, the triple Cambridge Blue, at full back. His deputy judged the ball badly, and several times put his side in danger. About a quarter of an hour had gone when Guy's got their try. The passing went to the right. Harkness threw to Rook, who failed to catch the ball; he kicked it though, and, following smartly to the line, gained an unconverted try. The Old Leysians, who played seven forwards, got to the other end, but Millett was in splendid form; he saved several times brilliantly, but at last a minor was conceded, and Guy's dropped out. By good passing the Old Leysians again threatened danger, but the backs tackled thoroughly. The forwards dribbled cleverly, and putting more "devil" into the game, reached the Leysians' "25," when Medlock goaled in good style from a mark.

After half-time, Guy's were unfortunate not to add to their total. A fine rush and follow up by Tweed almost ended successfully. Rook, on the other side, went into touch just as he reached the ball, but Harkness failed to pass to Curle, when a decent pass to the wingman would almost certainly have brought about a score. The last minute brought a score to the Old Boys, J. V. Fiddian, the Old Bart.'s Captain, successfully ending a forward rush with a try that Mellor failed to majorise. Final score: Guy's 1 marked goal, 1 try (6); Old Leysians, 1 try (3). Teams:—

Guy's.—H. Millett (back); C. L. Curle, A. H. Harkness, G. B. Pritchard, A. F. Rook (three-quarters); L. R. Broster, C. H. Medlock (halves); C. S. L. Roberts, W. S. Stranack, O. Parry-Jones, M. Tweed, A. B. Danby, A. L. Liebson, H. P. Whitworth, E. F. Llarena (forwards.

Remarks.—The forwards were not so good as usual in the scrums; the opposing "seven" got the ball too frequently, but their loose work, and especially the combined rushes, was excellent. Both halves were very fine. The three-quarters showed distinct improvement, except that Curle was given the ball far too seldom. Their tackling was thorough, and they got among the opposing threes very swiftly. Millett's form was quite up to International status.

GUY'S v. MIDDLESEX.

Having had a bye in the first round, Guy's had Middlesex for their opponents in the second round of the Hospital Cup Ties on February 13th. The side was not fully extended, and eventually ran out easy winners by 26 points to 5; 4 goals and 2 tries to 1 goal. It was rather a one-sided game, for quite three parts of the play was fought out in Middlesex territory. The last twenty minutes or so was more even. But during this period Guy's left their backs to look after themselves, and practised some wheeling movements. Guy's first try was gained by Pritchard who burst over the line in good style after some clever handling, initiated by Broster and Medlock. The next try was rather a gift as Hay waited for the ball to bounce; but Rook dashed up and secured to get over, Medlock goaling. Broster dodged over soon after and Medlock again did the needful. Medlock had then a shot from a penalty. The range was a long one, but the leather hit the cross-bar. It was a fine attempt. Pritchard got in once again before half-time, and ends were changed with Guy's 16 points to the good.

The forwards had played very finely, Moberly playing a remarkable game. It was his first time out since last year's Final. His display was wonderfully good. The other seven played a good game and have settled into a pack far above the average.

The second half brought two more tries, one by Moberly and one by Broster. Medlock was successful with both places. The Middlesex score was the result of some very fine passing. The ball was eventually punted over Millett's head, and Hayes got the touch for Gale to convert. Final score as above. Team:—

Guy's.—H. Millett (back); C. L. Curle, A. H. Harkness, G. B. Pritchard, A. F. Rook (three-quarters); L. R. Broster, C. H. Medlock (halves); C. L. Roberts, W. S. Stranack, O. Parry-Jones, M. Tweed, A. L. Liebson, A. B. Danby, H. P. Whitworth, A. V. Moberly (forwards).

Remarks.—Millett's display was very fine, and the same remark applies to both half-backs and the forwards. The three-quarters were not very good. Harkness does not use Curle anything like enough. Pritchard was the best. Rook's cross-kick is useful, but he must not overdo it. Rook must not get in front of Pritchard, he has a habit of over-running his passes.

Association Football.

FIRST ROUND INTER-HOSPITAL CUP.

Played at Chiswick, on Thursday, February 6th. Guy's kicked off and at once started to press. Their goalkeeper was tested on several occasions. Herman, the London centre-half was responsible for some fine defending work, and saved his side many times. At last their left-back mis-kicked, this let Coxon in on the wing and he centred across to H. V. Stebbings who was unmarked, and the latter scored easily. Shortly after-

wards the same player shot into the net, but was ruled offside. Whelton was not tested very much by the London forwards. Guy's led at half time 1 goal to 0. On resuming, Guy's had much more of the play, and H. V. Stebbings scored after following up a mis-kick by their left-back. Guy's won 2 goals to 0. Team—

Guy's.—F. E. Welton (goal); J. Kyle, F. J. Biddle (backs); R. M. Veale, D. A. Bevis, L. Gill (halves); J. R. Cox, A. C. M. Coxon, H. V. Stebbings, J. M. Stebbings, R. C. W. Staley (forwards).

Remarks.—D. A. Bevis played a very good game in spite of his bruised shoulder. The forwards were disappointing in front of goal.

SEMI-FINAL INTER-HOSPITAL CUP.

Guy's v. St. Thomas's.

Played at Winchmore Hill, on Saturday, February 22nd. The play was very even during the first half. About twenty minutes after the start Welton ran out to clear, but kicked the ball to one of the opposing forwards who scored a single goal. Guy's put on some pressure afterwards, and Veale just missed the goal. Coxon shot at goal but Cranstoun rushing out smothered his shot. H. V. Stebbings gave Veale a grand opportunity to score, but failed to take the pass. At the interval the score was St. Thomas's 1; Guy's 0.

On resuming, Thomas's scored again after Welton had fallen full and tipped the ball out of goal. From the kick off, Guy's took the ball down and Coxon shot a good goal from 25 yards out. St. Thomas's replied quickly and scored again through Roberts. After this, Guy's went to pieces. The forwards dribbled far too much. St. Thomas's scored twice again, making the score 5—1. Veale got away but was badly tripped, and J. M. Stebbings scored from the penalty. After this, Guy's had all the play. R. M. Veale took a pass from H. V. Stebbings, and scored the third goal. Just before the end St. Thomas's scored again, making the final score 6—3 in favour of St. Thomas's. Team—

Guy's.—F. E. Welton (goal); J. Kyle, F. J. Biddle (backs); E. Phillips, D. A. Bevis, L. Gill (halves); A. C. M. Coxon, R. M. Veale, H. V. Stebbings, J. M. Stebbings, R. C. W. Staley (forwards).

Hockey.

INTER-HOSPITAL HOCKEY TOURNAMENT.

Semi-Final Round.

Guy's played London in the semi-final round on Thursday, February 13th. After a very keen game the result was a draw of 2—2 at time. An extra ten minutes each way was played, but the result was still left drawn at 3—3.

This game was marred by an unfortunate accident to Guy's energetic secretary, Purdom, who at the end of five minutes' play was badly concussed, and had to be carried off. This is the second time he has been concussed this season.

Owing to this accident Guy's had to play with only ten men for practically the whole game, and are to be congratulated on securing a draw. The whole team played up well, especially the defence, which at one time was subjected to severe pressure.

GUY'S v. LONDON.

Replayed Semi-Final.

This match was played on Thursday, February 20th, at Richmond Athletic ground. For Guy's, Parry was crocked with influenza and Purdom was not fit from his accident the previous week. This left Guy's team—A. C. M. Coxon (gaol); O. G. Morgan and G. D. Gripper (backs); C. R. Smith, R. W. P. Jackson and J. F. Venables (halves); C. Vincent-Browne, L. Bromley, E. P. Poulton, L. A. Graham (capt.), and A. R. Crowe (forwards). The ground was rather fiery with the result that the game was tremendously fast. From the beginning until the last fifteen minutes of the game the sides were on a level, and it was impossible to say that either side deserved to win. But after this—during the last quarter of an hour of play—Guy's forwards started passing in their proper style and then it was obvious that we were the better team. But it was only by brilliant play that we managed to win. One could not have wished for a keener game and it was worth going a long way to see. Guy's started off up the hill, and the whole of the first half, the defences prevailed against the attacks. The London forwards were very clever, but Jackson was brilliant at centre-half and the other halves and backs were very sound. Coxon saved once in marvellous fashion, and cleared while sitting on the ground. Our forwards were obviously worried by the bumpy nature of the ground, and there was not enough of that passing which characterised our display against King's College Hospital. Had they been able to get together properly, as they did right at the end of the game, the result would have been settled sooner. As it was, they were clever individually, but there was something wrong. Poulton seemed slow in getting in his passes. Bromley was very good and well deserved the two goals he got. Browne put in a lot of very useful work, and twice in particular he was brilliant in two long runs which deserved goals, from one of which Bromley, obtaining a pass, shot outside the goal, and the other one was abruptly stopped by the right back in the circle. The London defence was very good. Moss at centre half, and also the right half and left back being very fast and sound. The second half was a repetition of the first. There was a lot of hard, clean hitting, but neither side could claim any advantage. Both goalkeepers had to stop some hard shots which they did very

successfully. Time came without any score, and it was settled to play an extra ten minutes each way. Guy's immediately started off with a rush, and after pressing hard, Bromley scored a splended goal. London promptly replied, Hennessey running through from the bully off, and scoring high up in the right-hand corner which gave Coxon no chance. No further scoring took place, and at the the end of the extra twenty minutes the result was 1—1. London Hospital were very keen on going on another extra twenty minutes, so we started off, and it was then that Guy's forwards began to work together. Guy's gradually began to have more of the play than their opponents, but for some time they could not score. After the first ten minutes, however, they had to play downhill, and they pressed continually for the last ten minutes. A nice passing movement started in midfield between Graham, Poulton, and Bromley, and the last-named finally ran right through and passed to Poulton who scored a good goal. Following this there were further rushes and London seemed played out. Finally, Browne and Bromley took the ball down and the latter, after working cleverly for a good position, shot the ball through from a difficult angle and put the result beyond doubt. There were only a couple more minutes to play, but although London tried to rush through, Guy's were distinctly the better side, and then the whistle went leaving us winners by 3—1.

It was a game that will long be remembered by those who played and watched. Venables had had no training for some time, but managed to last well, and although he was often beaten by the ball bouncing, he nearly always got back in time. Both backs played very well, Gripper keeping on very pluckily after getting a nasty bang on the hand. It would, perhaps, be unfair to single out each player and describe his game. All the Guy's men played splendidly, and Jackson was simply brilliant. London also played very well—Hennessey, Moss, and Evans in particular.

Guy's have now qualified to meet Bart.'s in the final. We hope a lot of Guy's men will turn up to watch. We were very pleased to see Mr. Fagge, our vice-president, on the ground last Thursday.

Pass List.

Conjoint Examining Board, R.C.P. Lond., and R.C.S. Eng., January, 1913.

FINAL EXAMINATION.

MEDICINE, SURGERY AND MIDWIFERY.

*Godding, H. C.
*John, D. W.
*Wright, L. D.

MEDICINE AND SURGERY.

*Moore, A. G. H.
*Watkin, P. J.

MEDICINE AND MIDWIFERY.

Collar, F.
*Garrard, N.
Kemp, J. W.
Pickering, D. V.

MEDICINE ONLY.

*Clifford, A. C.
*Garrett, G. W. B.
*Henry, A. M.
*Menagé, L. M. J.
*Morgan, O. G.

SURGERY ONLY.

Bull, F. B.
*Danby, A. B.
*Hunôt, F. C.
*Keer, K. J. T.
*Leigh, H. V.
Lewis, J. L. D.
*Pochin, C. H. G.
*Ryle, J. A.
*Shearwood, A. L.
*Wickenden, S.

MIDWIFERY ONLY.

Annesley, F. D.
Berry, P. H.
*Eccles, G. D.
King, G. W.
Mahon, E. M.
Mather, H.
Penny, C. H. G.
*Perceval, J. L.
Pratt, G. A,

* Denotes completion of Examination.

Diploma in Public Health.

Percy Rose, L.R.C.P.

Births.

HOLLIST.—On February 5th, at Riseley Lodge, Maidenhead, the wife of G. W. C. Hollist, M.R.C.S., of a daughter.

JORDAN.—On February 19th, at 11, Bentinck Street, W., to Dr. and Mrs. Alfred C. Jordan, a son.

PIPER.—On January 24th, at Gullane, Kingston Hill, the wife of Stanley Piper, L.D.S. Eng., of a son (Robert).

Marriage.

CROOK—WETHERBEE.—On January 23rd, at Rosslyn Hill Church, Hampstead, by the Rev. Dr. Edwin Odgers, uncle of the bride, assisted by the Rev. Henry Gow, Arthur Henry Crook, M.A., M.B., M.C. Cantab., F.R.C.S. Eng., second son of S. B. Crook, Esq., of Overstrand, Shanklin, Isle of Wight, to Margaret, younger daughter of George Wetherbee, Esq., of 18, Redington Road, Hampstead, N.W.

Death.

MACALISTER.—On February 19th, at a Nursing Home, Norah Macalister (née Tandy), dearly beloved wife of George Hugh Macalister, M.D., 85, Prince of Wales' Mansions, Battersea Park, S.W.

Ed.—F. G. L. S.

GUY'S HOSPITAL GAZETTE.

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Passim.

OUR heartiest congratulations to "Captain" Pritchard and his team on their splendid victory over the London Hospital fifteen in the "Final"! Rarely has the match aroused such interest, and seldom have we seen such an exciting struggle. Soon after breakfast-time a few discordant blares, intermingled with sounds of rag-time music played at lightning speed, heralded the fact that it was Cup-tie Day; and, shortly before noon, the statue of our worthy Founder was surrounded by hundreds of students, nurses, and "Boroughites" anxious to witness the departure of ten brewers' drays, heavily draped in blue and yellow, and "manned" by enthusiasts whose garments and "make-up" had meant great care and artistic choice. The journey to the ground, as usual, provoked endless amusement and afforded the newspapers ample material to preface their remarks on the match itself.

When the rival teams appeared on the field the exuberance of spirits was at its height, but the two factions sportingly called a "cease fire," in order to allow the more serious business of the day to be proceeded with satisfactorily. According to all accounts, there were over five thousand spectators present, and amongst them we were pleased to recognise Mr. R. C. Mullins, who captained Guy's through an anxious season a few years ago.

The match itself is described elsewhere. It was essentially vigorous in nature, and each player worked his level best in the stiff fight which resulted in a narrow win for Guy's. Our opponents played hard, and their backs deserve mention on account of the "great" manner in which they defended.

The same evening a dinner was given by the Inter-Hospital authorities to both teams, with representatives from other hospitals, and we cannot speak too highly of the way in which the London team acknowledged our supremacy, for one year at least, in Inter-Hospital Rugby football.

WE congratulate Mr. H. T. Depree on his appointment as Resident Anæsthetist at St. Mary's Hospital, Paddington.

WE are asked to publish the following notice:

> Wanted, a fully-qualified medical man willing to devote himself to missionary work among the Eskimos, who shall take charge of the Moravian Mission Hospital, at Okak, Labrador, and shall at the same time be the Medical Missionary for the whole of that part of the Labrador coast which lies within the sphere of the said Mission.
>
> Applications for the above-mentioned post to be addressed to the Secretary, Moravian Missions, 32, Fetter Lane, London, E.C.

WE wish to call the attention of our readers to the fact that Mr. R. M. Wingent's cartoons and programme designs have been issued in portfolio form—each cartoon being detachable for framing purposes. The collection includes all the drawings contributed to the GAZETTE

since the early part of 1910, and, for the first time, the popular "stork" and "vol-plane" subjects of Christmas, 1910 and 1911. Students who desire to avail themselves of this opportunity of acquiring what are undoubtedly the artist's best efforts, should apply to W. Gray, The College, from whom they may be obtained at 2s. 6d. post free.

The King Edward VII. British-German Foundation has sent us a Memorandum with reference to the Scholarships offered by the German foundation to English students who wish to study in Germany. The value of each studentship will range from a minimum of £100 to a maximum of £170, and are intended to assist the student to live in Germany in a German family for one year, with the object both of adding to his qualifications for his professional career, and of obtaining an insight into German customs and character. It is hoped that the wider knowledge of the German people which will be gained during their stay will help to promote a good understanding between the two nations. In selecting the students it is the intention of the Council to have regard to the means of the candidate, and to prefer those who would be unable to pursue a course of study abroad without assistance. They will also consider whether a candidate has shown, by the results of his studies in the United Kingdom, that he would be likely to profit from a course in Germany, and whether his personal character and disposition are such as to give a prospect of the satisfactory results which, it is hoped, will arise from personal intercourse and friendship. Applications will only be considered if forwarded by recognised educational authorities. They should be accompanied by full information as to the candidates' qualifications and means, and addressed to the Secretary, King Edward VII. British-German Foundation (United Kingdom), Denison House, Vauxhall Bridge Road, S.W.

Recent events have directed public attention to a method of administering food by compulsion in the case of certain ladies ambitious of securing the attention of mankind. We desire to suggest that such methods are not without analogy in the scholastic world. There is, of course, a difference, for no student is adverse to the possession of knowledge, but only to the labour of acquiring knowledge. He is ready to welcome any means of obtaining information in which another does the work and he has only to assimilate results. In a word, he prefers the infusion of knowledge from without, to the more laborious task of finding things out for himself. In this desire he is not unlikely to be seconded by his teachers, for no instructor is likely to be indifferent to the subtle flattery implied in the obsequious reverence paid to his opinions. Furthermore, his opinions are naturally of greater value in themselves than the guesses of inexperience. Progress, too, is made more quickly by the attentive learner than by the halting thinker, and rapid progress is of value when there is so much to be acquired. All this, and more might well be said in favour of the royal road to learning supplied by means of handbooks and digests, and yet it is well to be aware that there is a danger latent in such attempts to make learning easy. What comes easily goes easily, and an ounce of thought is worth a pound of the thought of someone else.

The diffusion of knowledge of which the present day is so proud, has proved disappointing. Half a century ago it was predicted that the increase of education would bring with it a corresponding increase in literary excellence. Where so many, it was said, are at work, the greater will be the number who will achieve immortality. The law of averages has stepped in to falsify the prediction. General excellence has, perhaps, been obtained, but it has been attained at the expense of extraordinary greatness. The level of the plain has been raised, but the material seems to have been supplied by the denunciation of the lofty summits. Real outstanding excellence is only gained by the conquest of difficulties, and it is just because difficulties are so often smoothed over by the indulgence of the teacher that genius delays to appear. It cannot be denied that this tendency operates very widely on all departments of learning. The frequent term "reading," which

is so constantly applied to the walk of a student, shows to how great an extent the pursuit of knowledge has been identified with attendance at the library.

Reading is a poor substitute for thinking, and too much reading gives little time for thought. Reading pays for examination purposes, but thinking pays best in the long run, and when examinations have faded into the dim distance then the time required for the two habits is inverted. Once reading came quickly and thought came slowly, but in after years the slow thinker has quickened his pace, and the reader cannot lay aside his work to study. Of course, reading will always be necessary, for there must be far more in the many-headed library than in the single cranium. Still, the thought which has been made portable is the easier to come at in an emergency, and, therefore, the more valuable. "Too little learning is a dangerous thing," but too much learning is quite as dangerous, when, as often, it has weakened the power of original thought. Agility of mind is preferable to the laborious tramp of the overloaded memory.

No rule can be given to decide the proportion between original and acquired knowledge, for individual capacity must be considered. Possibly the best line is the line of greatest resistance. Let the student who depends most upon memory be careful to cultivate his powers of reason and observation, let the rapid thinker be careful not to neglect his books. In making special insistence upon the need of original thinking, we only desire to help to redress the balance which is inclined to give its verdict in favour of the wide reader, and against the narrower thinker It is very largely a question of future as against present gains. At any rate, we have endeavoured to set the ball of discussion on the roll.

F. G. L. S.
R. O. H. J.

Change of Address.

Hubert V. Leigh, M.R.C.S., L.R.C.P., from Guy's Hospital, to Glyn Bargoed, Treharris, R.S.O., S. Wales.

R. F. Moxley, L.D.S., from Heathmere, Strensham Hill, Moseley, to 66, Bristol Road, Birmingham.

R. G. Heegaard Warner, L.D.S. Eng., 248, Brockley Road, Brockley, S.E.

Notes on some of the Hospitals of Paris.

II.

The Salpêtrière Hospital lies alongside the Pitié; it is one of the oldest and the biggest of all the French hospitals. To anyone who has not visited it, it is difficult to convey any idea of the size of the Salpêtrière. It contains nearly four thousand beds; its chapel is a big church with an octagonal tower; there are so many wards that the hospital has had to be built with named streets running among its blocks.

There are many lunatics among the patients, and it is much more akin to our infirmaries than to a general hospital; practically every patient is suffering from some form of disorder of the nervous system.

I went there on several successive Thursday mornings to the cliniques of Professor Dejerine. He gives public cliniques on three mornings each week, but it is only on Thursdays that he shows many cases; on the other days he lectures on a set subject.

The cliniques are held in the Salle Charcot, a large theatre holding an audience of several hundred. During the half-hour preceding the demonstration the audience collects, physicians of all ages, men and girl students, army officers, and a sprinkling of foreigners. At ten o'clock Professor Dejerine comes on to the platform followed by his firm. He lectures at a great pace, and a nurse brings in a series of cases illustrating the lecture. He gives a brief account of the history, and as he mentions the physical signs one of his internes demonstrates them on the case.

So vast is the supply of clinical material at the Salpêtrière that a full series of cases can always be obtained to illustrate a lecture on any branch of nervous disease. On one morning I saw a case of syringomyelia, six cerebral tumours, tubercular, gummatous, and sarcomatous or gliomatous, and three cases of Brown-Sequard's syndrome.

For a systematic demonstration of nervous diseases the Salpêtrière is the best place to visit, but the informality of Babinski's clinique is not to be found there, and one has not the same opportunities of seeing the cases closely.

Kirmisson's book on the Surgical Diseases of Children is, perhaps, the best existing on that subject, and it was for that reason that I visited the Hôpital des Enfants Malades. This is rather a beautiful old hospital standing in the Rue de Sevres, not far from the Gare Montparnasse. The wards are separated from one another by very broad gravel walks; little trees are planted in avenues here and there, fruit trees are trained up the walls of some of the buildings. I do not know how many beds there are, but

I think there must be at least six hundred. There is a large gymnasium and a very big isolation block where a number of diphtheria cases are treated.

I reached the hospital soon after ten o'clock, but found that Kirmisson had already finished his operations. I found him surrounded by a crowd of students in one of the wards. He is a short, elderly man, with a white "goatee" beard, he wears a white overall and white apron and a black smoking cap and hooded cloak. The cloak is carefully removed by the Sister as he enters, and as carefully replaced when he leaves. When I entered he was demonstrating on a child with a backward dislocation at the elbow-joint. For many minutes he told us how unfortunate it was that the modern "interne" reduced these dislocations before ever the professor had had an opportunity of demonstrating them.

Kirmisson is a great talker; he hardly gives the interne time to finish reading the history before his discourse begins; he showers questions on his firm, and answers them fully himself; he has that keen vivacity that one so often sees in Frenchmen. We hurried round each ward, going out into the open air between each block of buildings. It was a bright sunny morning, but all the ward windows were shut tight, and big stoves in the middle of each room made the atmosphere very stuffy, nevertheless the last of our flock of followers were never able to enter a ward quick enough to escape a shout from the professor—"Shut the door quickly, please, gentlemen, shut the door; the children will catch cold!" He would then hurry down the ward hissing out "Shh! Shh!" until everyone was silent, whereupon he would begin to volley out questions and answers once more.

Kirmisson, as would only be expected, has a very charming manner with his patients; none of the children appeared to be in the least afraid of him. At one bed we stopped, and the externe read a lengthy history of a violent attack of abdominal pain and vomiting beginning the previous evening. Everything except the child's face suggested general peritonitis. Kirmisson drew down the bedclothes and with infinite care began to palpate. To all his questions as to tenderness, the child replied with a shake of its head; gradually he pressed deeper and deeper in until it was evident that there was nothing left of the previous belly-ache; with an angry grunt the professor jerked back the bedclothes and rushed away to the next case, leaving the externe (who was a Russian girl) rather sorry that she had not explained the subsequent improvement in the patient's condition.

As soon as we had been round the wards we all followed the professor to a large lecture room. When we were all seated, the boy with the dislocation was brought in again, and Kirmisson, after repeating his remarks as to the evils of hasty reduction, demonstrated the clinical features of the case.

A basin of soup was then put on the table, and, after the patient had been removed, the professor called over a list of names. I began to get rather uneasy, and soon found that I had reason to be so, for he proceeded to lecture on hernia in children. The externes seemed to find it very interesting, at any rate they took down very full notes, with illustrative drawings of the different sacs. The professor seemed very absorbed in his subject, pouring out statistics of the relative occurrence of the inguinal and femoral varieties, and almost screaming at us when, with excited gestures, he demonstrated the essential difference of the umbilical from all the other kinds, but I personally began to be aware of the smallness of my breakfast, and the enjoyment with which Kirmisson drank his soup became very painful. I was glad when the final spoonful led to the conclusion of the lecture, and after we had all gone to a theatre to see the final reduction of the elbow, I rushed away for an expensive lunch.

T. I. B.

Operation for Strangulated Inguinal Hernia under Local Anæsthetic.

MAN, aged 74, suffering from left hemiplegia and bronchitis, had two inguinal herniæ—a large one on the right side, which reduced with a gurgle, and a small one on the left side about the size of a hen's egg, which was hard and irreducible; fluctuation was present, and the swelling was dull on percussion. An operation was decided on, and then arose the question of anæsthetic. Considering the hemiplegia, the bronchitis, and the fact that his arteries at the wrists were like pipe stems, it was decided to give an injection of novocaine and adrenalin under the skin. A tablet of novocaine and adrenalin was dissolved in ʒii. of water, and ʒi. of the solution was injected under the skin over the hernia. After waiting for twenty minutes for anæsthesia to be produced, an incision about three inches long was made over the swelling, and the sac was opened; fluid escaped which was under pressure. The ring of the sac was incised and the knuckle of gut returned; the sac was then dissected out and ligatured off, after which the muscles and skin were sewn up, the whole operation taking a very short time. The patient hardly grumbled and was quite comfortable as soon as he was back in bed. The wound healed by first intention, there being no rise of temperature or local reaction. Stitches were taken out at the tenth day, and the patient is doing well.

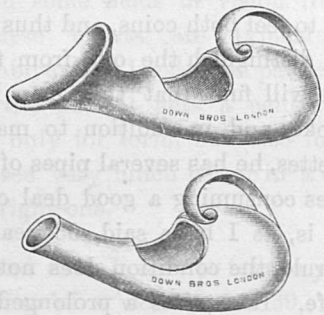
The hernia was diagnosed early, and the patient had not vomited: he was able to take nourishment by the mouth shortly after the operation.

G. R. HIND.

Specialities.

The Cleansable Urinal.

(Registered.)



In bringing out this appliance, suggested by Sister Hodnett, of West Ham Union Infirmary, Messrs. Down Bros., Ltd., of St. Thomas's Street, London, have supplied a long-felt want in the hygiene of the ward and sick-room. The modification on the usual pattern of vessel is quite simple, and its purpose obvious from the illustration.

The effectual cleansing of these receivers has always presented a difficulty, owing to the need for construction on lines to ensure the desirable degree of retention of their contents and the prevention of the inlet from inopportunely becoming an outlet. In this model, while these lines are in no wise departed from, an additional opening is provided which will admit the hand or a mop for thorough cleansing.

Improved Ice Cradle, for the Reduction of Temperatures in Enteric Fever, etc.

(Patent.)

For this apparatus, which has been made at the suggestion of Miss K. C. Braidwood, Matron of the Hospital for Infectious Diseases, Mylands, Colchester, the following advantages are claimed :—

1. Avoidance of all discomfort to the patient, who also need not be moved.

2. A great saving both of time and labour is effected as compared with that involved in the use of other methods such as baths, packs, etc.

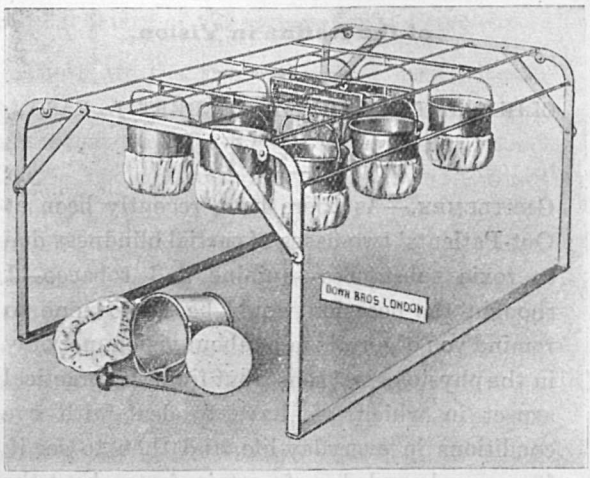
3. The apparatus can be easily managed by one nurse.

4. Convenience in carriage and storage. The cradle folds flat when not in use.

The cradle is in the form of a light metal framework, from which are suspended at equidistant points a set of eight ice pails, supplied with strainers and with flannel covers fitted to the lower part of the pails. These caps absorb the moisture due to condensation, so that there is no dripping. An ice-pick is provided for use when filling and replenishing the pails.

The arrangement of patient and cradle is as follows:—

The patient wears a flannel gown and bed-socks, or is covered with a thin blanket, and has a hot-water bottle at the feet. The cradle is then adjusted (well up over the trunk), the pails are attached, and the thermometer put in place.



Two blankets are arranged over the cradle to open in the middle, so that the thermometer can be noted without any inrush of cold air. As the temperature begins to drop, one or more pails can be removed, so that the patient does not get chilled. As a rule, the cradle is put on when the patient's temperature is 102° F. and removed when it has dropped to 101°. With temperatures over 103°, the plan followed has been a preliminary sponging, which will bring down the temperature more quickly, before applying the cradle.

The nurse notes the recorded cradle temperature each time when taking the patient's temperature, and keeps the ice-pails replenished. This is only the work of a moment if two bowls are brought to the bedside—one empty for draining the pails, and one containing a fresh supply of chipped ice.

The makers are Down Bros., Ltd., 21–23, St. Thomas's Street, London.

University of Cambridge.

SECOND EXAMINATION FOR MEDICAL AND SURGICAL DEGREES.—EASTER TERM, 1913.

New Regulations.

Part II.—Pharmacology and General Pathology.

Order of Examination (subject to alteration in details, of which due notice will be given.

Tuesday, Wednesday, and Thursday, April 22nd, 23rd, and 24th, 9.30 a.m. and 2.30 p.m., Oral and Practical Examinations in Pharmacology and General Pathology, in the Medical Schools.

Cases of Quinine and Tobacco Amblyopia,

And the Functions of the Various Elements of the Retina in Vision.

CLINICAL LECTURE BY HERBERT L. EASON, M.D. M.S.

Gentlemen,—As there have recently been at Out-Patients' two cases of partial blindness due to toxic substances—quinine and tobacco—I thought the occasion would be a good one to remind you of certain facts about vision, not only in the physiological sense, but from the practical aspect in which we have to deal with eye conditions in everyday life, and then to see if, from our knowledge of certain facts about the anatomy of the retina, we can arrive at any conclusion as to the particular parts affected in these cases of defective sight from toxic causes.

The first of the cases I have to mention is one of tobacco amblyopia. The patient is a man, æt. 53, a barman, and his occupation is rather important. He complains of defective sight, which he has noticed increasing for the last month or two. He cannot see things at a distance distinctly, or read properly. He can see large objects, and so does not have much difficulty in getting about, but he cannot read the largest type on our test boards. In fact, his vision is reduced to less than one-tenth. Leading questions reveal the fact that he sees better in a dull light than in a bright one, and if he goes out into the street in bright sunlight he is much dazzled and his vision is bad. With the onset of twilight, or in a room moderately lighted, his vision improves. He also notices that his vision for colours has become very defective; he cannot see red and green objects so well as he could, and he makes mistakes about the colour of coins. He cannot distinguish without a great deal of difficulty the difference between a sixpenny piece and half a sovereign; and this is the kind of defect which may lead to him being discharged because he has given, perhaps, nine shillings change out of a sixpence. He needs to feel both coins, and thus judge by weight, to distinguish the one from the other. Then you will find that this man is a very heavy smoker and, in addition to many cigars and cigarettes, he has several pipes of tobacco a day besides consuming a good deal of alcohol. This man is, as I have said, 53 years of age, and, as a rule, the condition does not come on in early life. It requires a prolonged course of steady smoking to produce the effect. On testing his fields of vision, you find the vision is good at the periphery; but if you test the central part of the field you find that, when looking direct at anything, he cannot distinguish colours; in other words, he has a central scotoma for colours. If he looks at a red object, he does not see it as red; it looks brown, or a dirty black. But if a red object is so placed that he sees it with the periphery of his retina, he does see it red. The same may be true of green, but his defective vision for that colour extends over a wider area. He can still tell blue at the centre, for blue is the last type of colour to go in this sort of case. There is very little that is abnormal to be seen in the fundus, except at the outer side of the optic disc, which is somewhat pale. You can test the scotoma for colours by means of small discs of coloured paper moved about, but the most ingenious test is one which was devised by Captain, now Sir, William Abney, who used a white dish, with beads of many colours in it, including, of course, red, green, and blue. As the peripheral vision for colour is very good in these cases, the subject of the amblyopia can see colours in the periphery of the dish; but ask him to pick out the green beads, for instance, and you find that, directly he looks at a particular bead, its colour vanishes, and he cannot pick it up. It

is very interesting to see how these people hesitate when asked to pick out the colours. Remember, the man can see the colours on the outer edge of the field, but not in the centre. I show you some fields of vision from these cases. These charts are typical ones of tobacco amblyopia. I ask you particularly to remember the patient gets a central loss of vision, not only for form, but also for colour. They also see very much better in a dull light than in a bright one.

The second case I wish to talk to you about to-day is that of a woman, æt. 39, who was sent to me by Dr. Cutler, of Walton-on-Thames, in the middle of December. She was a stupid woman, and, for some freak or other, a month before she was sent to me, swallowed half an eightpenny bottle of quinine. I have not been able to ascertain the exact dose that she took, but it was a very heavy one. I am not sure whether she had suicidal tendencies. Next day she found her sight was very defective, and it has remained so ever since. I saw her only last week again, three months after the occurrence, and the sight still remains extremely defective; but the defect is of a different kind from that of the patient suffering from tobacco amblyopia. Her vision for test types, both at a distance and near to, is good, and she has no colour defect, but she has a very limited field of vision, as shown by the chart I pass round. Instead of being a full-sized field, like the tobacco case, it is irregularly constricted. With the peculiar field of vision she has another symptom the exact antithesis of that from which the tobacco case suffers. She complains of night-blindness. She can see to get about comparatively well during the daytime, though she may stumble over things, because of the constricted field: but at nighttime she is, to all intents and purposes, blind. On looking into her eye, we find a very characteristic appearance. The optic disc is extremely pale, and the retinal arteries are contracted down to the size of mere threads. The contraction of the retinal arteries is so extreme that it resembles the condition which you see where there is an embolus in the central artery of the retina.

These are the two cases, then, which I wish to speak about to-day, and I would remind you again that they are the antithesis of each other. Of the two, the tobacco amblyopia is the more common kind. It is usually produced by smoking large quantities of strong tobacco, such as shag, in short clay pipes. Practically never is it brought on by cigarette smoking, the latter producing chiefly heart affections and dyspepsia; but it is possible to produce tobacco amblyopia from excessive cigar smoking. The largest number of cigars I have heard of as being smoked was in the case of a man who came home from India with tobacco amblyopia. He had been smoking five hundred green Burmah cheroots a month, which, of course, is equal to about eighteen a day. The reason that amblyopia does not so generally affect cigar smokers is that the alkaloids and other derivatives evaporate more readily in the atmosphere from a cigar than from tobacco smoked in a pipe.

Quinine amblyopia is rare, particularly in England; but, of course, as you would expect, it is less rare in countries where malaria is rife, and where, therefore, regular quinine taking is common. The smallest dose of quinine which has been known to cause amblyopia is five grammes, taken during a period of thirty-six hours. The maximum amount recorded was seventy-eight grammes, spread over three days. In malarial countries people may often be found suffering from some slight quinine poisoning, of which amblyopia may be a symptom, but it does not lead, as a rule, to the severe loss of vision such as this woman is suffering from. The prognosis in severe cases

such as this, is, as a rule, bad, and this woman will probably not recover her sight to any great extent.

I want now to consider with you some facts about vision. Vision is of use for three purposes: (i.) to distinguish shape or form, otherwise acuity of vision; (ii.) perception of the intensity or brilliance of light; (iii.) colour vision. The vision for form is extremely accurate, as a rule, and very acute. The ordinary person can see two lines or dots, separate from each other when they subtend an angle of one minute of arc. To give you an idea in common objects, you can usually distinguish two dots as distinct objects at a distance of two hundred feet if they are separated by a distance equal to the diameter of a sixpenny piece. You will see from that that our ordinary visual acuity is fairly good. All the best types we use in ophthalmic practice are based upon that scale. There are some people who have a much higher visual acuity than that. Mr. Lindsay Johnson tells of a negro boy who could count without aid Jupiter's satellites, and plot out exactly where they were. For most people a Zeiss glass, magnifying six or eight diameters, is required for this. But we find that pigmented and barbarous races have, as a rule, exceptionally high visual acuity.

I want you to remember, in the next place, that the area of the field of vision in which you see distinctly is very limited; it is no greater than the area covered by your thumb nail at arm's length. You should also appreciate that it only takes one-tenth of a second to get a complete visual impression; and, owing to this fact, and the rapidity of the movements of the eyes, one does not feel inconvenience from the smallness of the area of acute vision. The rest of the visual area is only moderately good for form, but for the perception of small movements the periphery is best. It seems to be a relic of an old defensive and protective instinct. With regard to brilliancy, we see better in high lights with the centre of the field; and the efficiency of the vision for form increases with the brilliancy of the light. But you may not be so familiar with the fact that all of us have a central defect for vision in low lights. If this room were to be darkened, and in front of a black screen were placed a small piece of white paper, you would not see that so well when looked at in a direct way, as when the image fell on the periphery of the retina. So remember that with minimal illuminations we have a central scotoma for form. That fact has been known by astronomers for hundreds of years, more especially before the age of telescopes. On looking directly at a constellation of small stars, such as those of the Pleiades, you cannot count the stars; but if you fix your vision a little above or below, or a little on one side, the stars will appear brighter, and you can count them. Thirdly, your field of vision for colour is not a bit like the field of vision for white. For white it is fairly extensive. I can see my hand when I hold it out on a level with my ear while I am looking straight in front of me and over about 75 degrees on the nasal side, so the vision for white extends over an angle of about 160 degrees, the field being roughly circular in shape, except where it is cut off by the nose. The next largest field to the white is that for blue; the red is smaller still; and the green smallest of all. If you sit down in front of the perimeter and test the colour fields, it is surprising how close the green must be brought to your fixation point before you recognize it. I show you a chart of the visual fields for the several colours. To test this properly, the subject must never know what colour is coming from the periphery; the question must be, "Can you recognise what colour it is?"

To summarize, the central field of vision is good in bright lights, good for colours, and

for form. Peripheral vision is bad for form, good for small movements, and better for seeing in low illuminations than in high.

I want to pass on from those notes on vision, to take a survey of the retina, and deal to some extent with its various elements, and see what they have to do with vision. I need hardly remind you of the layers of the retina; how a ray of light entering the eye hits the retina, first falling on the layer of nerve fibres. Below that are the ganglion cells, the nuclear and molecular layers, and the rods and cones; and the rods and cones have their heads stuck on the pigment layer of the retina, which lies on the choroid. Which layer of the retina is it that sees? Is it the nerve fibre layer? It is not the nerve fibres. You will remember the very old experiment invented by Marriste in the time of Charles II. for demonstrating the blind spot. You look with one eye at a cross on a piece of paper, on which there is also a round spot some distance external to the cross, and you move the paper to and fro until you happen on a position when the spot disappears. That blind area in your field of vision corresponds absolutely with the site of entrance of the optic nerve into the eye where all the nerve fibres are gathered together, and if the nerve fibres had anything to do with vision you ought to see over the blind spot; but you do not. You instinctively fill in the spot with the impressions which you get from the surrounding parts of the retina. But really it is a very large defect. The blind spot is so large that it will even obscure a man's head at a distance of a little over a yard. Another illustration of its size is that it will cover eleven full moons side by side. The visual layer of the retina has been shown to be that of the rods and cones by the old experiment of Purkinje. If, in a dark room, you have a candle, or other brilliant object, to one side, and you look away from it so that the light falls on the sclerotic, you are able to see a branching image of your retinal vessels, the shadow of them being thrown on to the retina. So the visual layer must be behind the retinal vessels, and calculation shows that it corresponds in depth to the layers of the rods and cones. It is therefore held—and no doubt it is true—that the visual layer of the retina is the rods and cones.

The rods and cones by themselves do not see without the pigment on which they are resting, and you know this from the fact that an albino, who has very little pigment in his retina, though his rods and cones are good, sees only defectively. In detachment of the retina also, where it strips away from the choroid, vision is lost, the retinal pigment layer remaining behind on the choroid. If the retina goes back, even after the lapse of months or years, directly the rods and cones get back into apposition with the pigment, vision is restored over the whole area. Therefore, vision has something to do with the pigment epithelium and the rods and cones. You know also that the rods and cones are not uniformly distributed. At the yellow spot in the retina, which I have already spoken of, the area of distinct vision, there are all cones, and no rods. Towards the periphery of the field of vision the cones become less numerous and the rods more numerous, till, at the periphery, there are practically all rods, and very few cones.

Taking these facts and associating them with our knowledge of central and peripheral vision, we can work out a hypothesis, which is probably true, as to the function of the various elements of the retina. This theory was originally propounded by von Kries. He said that the function of the cones is different from that of the rods. The cones have to do with the perception of form. They are for very acute vision; they see things such as small letters, and anything which needs to be very clearly defined. The cones have also the perception of

colour; but you see colours best in the centre of the field of vision, and as you get towards the periphery you see the colours less well. Finally, the cones do not act well in minimal illumination, as is shown by the central scotoma in low lights. The rods are very acute in seeing small movements. That, as I have already said, is probably a remnant of the protective instinct for seeing things coming from behind or at one side. The rods work better and more effectually in dim illuminations. All nocturnal animals and birds have retinæ containing rods nearly exclusively, and that is why they cannot see at all well in a bright light. They have not sufficient cones for the purpose.

With this knowledge as to our vision and as to the function of the rods and cones, we can go back to the cases of tobacco and quinine amblyopia. You will see that tobacco amblyopia must probably be an affection of the cones, because the function of the cones in that disease is destroyed. The colour vision has gone; it is worst at the centre where the cones are grouped together. The patients do not see well in bright lights, and always better in a low illumination, and they have lost their perception of form. Which toxic element in the tobacco is the poison to the cones I do not quite know; but it is probably not the nicotine, but rather pyridine or other alkaloids. The cones probably degenerate, and there is atrophy of the nerve fibres, which accounts for the pallor at the outer side of the disc which you find in long standing cases of tobacco amblyopia. Or there may be a necrosis of the central fibres of the optic nerve. Tobacco amblyopia is a curable condition; and, if the patient will give up smoking, vision is, as a rule, restored. It is quite impossible to treat tobacco amblyopia with any hope of success whatever unless the patient knocks off his tobacco absolutely. And you cannot compromise the matter by allowing him to smoke a few cigarettes or a cigar or two, or to chew. If abstinence is observed, in two or three months he will probably begin to get back his vision; and, persevering in this, it may be entirely restored in five or six months. But you must not hope for this result in a shorter time. Recovery may be hastened by giving strychnine, or other tonics; but *the* essential is the abstinence from all tobacco.

The effect of quinine is the exact opposite, for it poisons the rods, or, at any rate, it causes such extreme constriction in the retinal arteries that the circulation in the periphery of the retina is so bad that the rods do not get sufficient blood supply. Hence a patient suffering from quinine amblyopia is practically rod-blind, though the cones still work well. The central field of vision is good, for these patients can read and write and see colours, but the peripheral vision has gone, and so they have the sort of sight that you get if you look down a roll of paper and try to find your way about the room under these circumstances. You see anything directly in front of you, but you easily stumble over chairs or other objects, as you have no peripheral indirect vision. And the cones are of very little use at night, so a patient with quinine amblyopia has not got the faculty of seeing under minimal illumination.

Unfortunately, the prognosis in the case of quinine is much worse than that in tobacco. The extreme constriction of retinal arteries which follows these large doses of quinine seems incurable. We have tried in this case all sorts of vaso-dilators—trinitrine, amyl nitrite, and so on—but the vision is no better, and probably the patient will suffer from degeneration of the peripheral parts of the retina, and it will then be hopeless to expect any improvement in the condition. In a slight case one should at once stop the quinine, and use the vaso-dilators which I have mentioned; but severe cases seem hopeless.

Cases from the Throat Department.

A Case of Deep Abscess in the Tongue.

George G., aged 45, a horse-keeper, attended at Mr. Mollison's Out-Patient Department on February 5th, complaining of inability to swallow, and earache.

Seven days previously he had first noticed some swelling of the tongue and of the left side of the neck, and he had also a sore throat.

Two days later he was unable to swallow, and for the following four days he took no food at all, owing to pain on swallowing.

He then came to the Front Surgery; a diagnosis of pharyngitis was made, and a gargle, a purge, and formalin tablets were prescribed.

When seen the next day at Out-Patients, the chief complaint was of pain in the left ear, and dysphagia. The patient had managed to swallow a little water the previous evening.

An examination of the ears did not help the diagnosis; the membranes were normal in appearance.

Although there was some inflammation of the fauces and posterior pharyngeal wall, nothing was at first found to account for the four days' absolute starvation from dysphagia.

Mr. Mollison, however, on examining the patient, pointed out that the left side of the tongue was slightly, but distinctly larger than the right side; that, while the right side could be easily pressed down on to the floor of the mouth, the left side resisted the use of the tongue-depressor and was obviously very tender; and that, on examining with a laryngeal mirror, a definite tumour —as large as a walnut—could be seen on the surface of the posterior or vertical part of the tongue on the left side; that is, almost in the root of the tongue.

A diagnosis of abscess in the tongue was then made.

The patient was admitted under Sir Alfred Fripp, who kindly gave his permission to have these notes published. Sir Alfred Fripp decided to operate without delay.

A median incision was made at about the level of the circumvallate papillæ, and a grooved director was inserted through this incision laterally into the tumour. A quantity of pus escaped. The abscess was freely opened by cutting along the groove of the director. No attempt was made to drain or pack the abscess cavity, the after-treatment consisting merely in the use of a mouth-wash. The patient made a complete recovery. The chief points of interest would seem to be:—

1. The rarity of the condition: ten cases only are recorded in the surgical reports of the hospital for the last fifteen years.

2. The ease with which the diagnosis of this condition, which is liable to dangerous complications, may be missed.

3. The fact that, as Mr. Mollison pointed out, any inflammatory lesion or neoplasm of the pharynx above the level of the aryteno-epiglottidean folds is apt to give rise to earache of a referred nature.

4. The method of approaching an abscess in the tongue, the incision being made in the middle line where the organ is comparatively avascular. By this means troublesome and somewhat inaccessible hæmorrhage is avoided.

A. C. C.

Two Cases of Frontal Sinus Suppuration.

A.—Acute Suppuration in the Right Frontal Sinus due to Bacillus Influenzæ.

Henry S., aged 19, was admitted to Barnabas under Mr. Mollison, on January 9th. Fourteen days previous to his admission he had what was thought to be influenza accompanied by nasal catarrh.

On January 4th he first noticed a swelling above the right eye, accompanied by considerable pain in the frontal region. These symptoms he ascribed to a blow he received from a football. He noticed also a yellow discharge from the right nostril.

The swelling increased, and the pain continued until his admission five days later.

On admission, the patient looked pale and ill. There was a swelling above the right eye extending well up on to the forehead; this swelling was a little red and extremely tender, so much so that it was almost impossible to try to elicit fluctuation, though this was easily appreciated when the patient was under the anæsthetic. The temperature was 100·4° and the pulse 92. On examination of the nose, typical creamy "sinus" pus was seen lying in the middle meatus.

A diagnosis of acute suppuration in the frontal sinus was made, and an operation was performed. Pus was found under the periosteum, stripping the latter from the bone, which was very soft. On opening the frontal sinus it proved to be very large, and full of creamy non-smelling pus. The anterior wall of the sinus was removed. The right middle turbinal was then removed and a free opening made from the sinus to the nose. A rubber tube, three-eighth inch in diameter, was left draining the sinus into the nasal cavity, and the wound in the forehead was packed with gauze. On the following morning the temperature was normal and remained so from that time. The constitutional symptoms disappeared.

On January 15th there was some pain in the right ear and perforation of the membrane took place, pus being discharged.

The patient made very good progress, and the wound in the forehead and eyebrow healed leaving almost no depression.

It is interesting to note that a pure culture of Bacillus Influenzæ was obtained from the pus in the frontal sinus and from the pus from the ear. There is no doubt that the acute otitis media arose from infection of the Eustachian tube by the pus from the nose. On admission both membranes were normal, and a further point of interest lies in the fact that a tuning-fork placed on the patient's head was heard in the right ear; this lateralisation of Weber's test to the ear of the same side on which there is suppuration in the sinuses about the nose has been recently pointed out by Dr. Glas; indeed, Dr. Glas goes so far as to say that the test can be used as an aid to diagnosis of suppuration in the sinuses about the nose.

B.—SUPPURATION, PROBABLY ACUTE, IN THE LEFT FRONTAL SINUS, WHICH POINTED AND BURST THROUGH THE UPPER EYE-LID.

Raffaelo B., aged 42, an Italian hawker of ice-creams and roast chestnuts, was admitted into Barnabas under Mr. Ormond, suffering from what appeared to be an abscess in the left upper eye-lid, which was swollen and purple. The patient said that this affection of the eye-lid started six weeks before admission, and followed upon the cessation of a nasal discharge from which he had previously been suffering.

On the day following admission there was a spontaneous escape of pus from the swelling in the eye-lid; an incision was made to enlarge this sinus and to provide free drainage. However, the sinus so formed continued to discharge pus, and four days later Mr. Ormond and Mr. Mollison on examining the patient found that a probe could be passed through the wound for about one-and-a-quarter inches in the direction of the frontal sinus, and bare bone could be felt. There was some abnormal thickening of the superciliary ridge on the left side, and also tenderness in this region. There was still considerable swelling of the upper lid and of the tissues on the forehead.

There was no pyrexia and no nasal discharge. A thorough examination of the interior of the nose revealed no pus, even after cocaine and hemisine were applied to the region of the middle turbinated bone.

A provisional diagnosis of suppuration in the frontal sinus was made and operation was undertaken.

An incision was made over the frontal sinus, starting from the old wound in the eyelid and the bone was laid bare with a periosteal elevator. There were signs of periostitis of the frontal bone, as evidenced by a roughness of the deep surface of the periosteum, due to the spicules of new bone which it was forming.

The bone itself was exceedingly soft and friable, and much more vascular than normal; further, two or three small sequestra were found.

The frontal sinus was found to be of large size, extending upwards for a distance of two inches, and outwards above the orbit to a point just beyond the centre of its upper margin.

There was practically no pus in the sinus, but the lining mucous membrane had undergone a polypoid over-growth, so that it filled the sinus, and could be removed in jelly-like masses; it entirely blocked the fronto-nasal duct, thus accounting for the absence of pus in the nose.

The operation was completed as in the case A. The patient is now making a good recovery. Cultivations from the material in the frontal sinus gave a pure growth of staphylococcus aureus.

These notes are published by the kind permission of Mr. Ormond and Mr. Mollison.

G. C. C.
A. C. C.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—ED., G.H.G.]

SIR,—A little while ago you printed a letter from Nurse Mallandaine, late of Guy's, asking for help for her Hospital and Missionary work in Africa. I shall be pleased to receive, acknowledge, and forward any sums which your readers may contribute. May I in this letter thank—

Anon. for 10/-
Miss R. for 2/6

Yours, etc.,

10th March, 1913. J. A. SHELDON.

Hockey.

At a meeting of the Blues Committee held on February 28th it was unanimously decided that members of the Hockey Team should be awarded Full Blues in place of the Half Blue previously awarded.

It was agreed that—

1. Blues should be so awarded that at the end of each season the Hockey Club should be represented by not more than eleven Full Blues.

2. To be eligible for a Blue a member must play in not less than two-thirds of the season's fixtures.

3. That the Hockey Committee should have the power of recommending for Half Blues any member they may consider deserving.

4. That this amendment should come into force from now onwards.

L. BROMLEY,
Hon. Sec., Clubs' Union.

Guy's Hospital Medical School

The Hospital, which is situated two minutes' walk from London Bridge, contains 617 beds.

Students are appointed to Dresserships and Clerkships in the Wards and Out-Patient Departments on the first day of January, April, July, and October. All Students hold the following posts in turn: Surgical Ward Clerk, Medical Ward Clerk, Post-mortem Clerk, Assistant Surgeon's Dresser, Surgeon's Dresser, Dresser in a group of Special Departments, Obstetric Dresser and Extern Obstetric Assistant. Numerous other posts are open for application.

The Medical School Buildings have all been erected or rebuilt since 1904, the Department of Anatomy in 1904, of Biology in 1905, of Physiology in 1910, of Chemistry in 1910, of Physics in 1910, and of Pathology in 1912. The Wills Library was presented in 1903, the Gordon Museum in 1905.

The Students' Club and Residential College were erected in 1890 at a cost of £21,000. The Club contains reading, dining, and smoking rooms, while the College affords accommodation for about 60 Students, who may be summoned to the Wards at any hour of the day or night.

Adjoining the Club are the Pavy Gymnasium, a covered swimming bath, and a squash racquet court. The Athletic Ground, of nine acres, is situated at Honor Oak Park, distant about 15 minutes by train.

FEES AND COURSES.

First Year—For Preliminary Science Course: 16 Guineas for 12 months or less period, deducted from the Entrance Fee payable as a Second Year's Student.

A special fee of five guineas is charged for materials for this course.

Second or Third Year. (after First M.B.):

Entrance Fee, 20 Guineas. Annual composition fee, 35 Guineas, including all necessary materials.

Fourth Year (after Second M.B.):

Entrance Fee, 10 Guineas. Annual composition fee, 35 Guineas, including all necessary materials.

Provided a Student has paid three annual composition fees, a proportionate rebate will be allowed from the last on his obtaining an approved qualification at any time within nine months of the last payment.

A Special Class, with daily tuition, for the Primary Fellowship Examination begins on March 1st and September 1st in each year. Entrance Scholarships to the value of £380 are awarded annually in September.

For further particulars, and permission to be conducted over the School Buildings, application should be made to

THE DEAN, GUY'S HOSPITAL, S.E.

Landon Out-Patients' Tea Fund, Christmas, 1912.

STATEMENT OF RECEIPTS AND EXPENDITURE.

Receipts.	£	s.	d.
To Balance brought forward from last account	9	18	6
„ Donations, Collections, etc....	81	5	7
	£91	4	1

Expenditure.	£	s.	d.
By Cost of Tea (Caterer's Account)	22	12	11
„ Groceries, Provisions, Fruit, etc.	13	8	11
„ Clothing	10	9	11
„ Toys	12	0	0
„ Cinematograph, etc.	9	18	0
„ Decorations	2	4	6
„ Printing, Stationery, and Postage ...	2	0	9
„ Police Fees, Gratuities, etc.	2	2	6
	£74	17	6
„ Balance carried forward— Cash at Bankers	16	7	2
	£91	4	1

Audited, compared with the vouchers and found correct. (Signed) CHAS. H. WELLS,
19th February, 1913. *Incorporated Accountant.*

Last Christmas teas were supplied to over 670 children between the ages of 6 and eleven years, in approximately equal numbers of boys and girls. They were entertained during the tea by the Hospital Nigger Troupe, and afterwards by a cinematograph performance. Presents of toys, food, and clothing were then distributed to them from the Christmas trees. At a meeting of the Committee on 25th February, 1913, it was decided that the whole of the balance available this year should be carried forward to the fund for next year.

We should like to take this opportunity of thanking all those who, by donations, collections, or personal interest, so kindly helped us to make the tea and entertainment successful.

G. T. FOSTER-SMITH,
A. C. JEPSON,
Hon. Secs.,
Landon Out-Patients' Tea.

Practical Surgical Hints.

II. Diagnosis.

In pyloric obstruction the vomiting becomes not merely more frequent, but more *regular* in occurrence.

In respiratory obstruction by a retropharyngeal abscess, (1) the cry is normal, (2) the tonsil may be pushed forwards, and (3) if it is, there may be a discharge from the nostril on the same side, caused by obstruction of the posterior nares.

Always admit unconscious persons who (1) are "fitting," or (2) who have unequal pupils.

Never probe a wound which may go into the abdominal cavity, or into a joint; take the patient in, and examine the wound by enlarging it under an anæsthetic, after properly cleansing the exterior.

Lateral mobility of the elbow means a fracture.

If an inflamed finger is held semi-flexed, the tendon-sheath is infected, and must be opened, the incision going right down to the bone.

When a young man gets a sudden, unexplained hydrocele, always think of tubercle as the cause.

A. H. T.

Papers by Guy's Men.

Kenneth Black, F.R.C.S.: A Method of Performing Gastro-jejunostomy. (Read before the Nottingham Medico-Chirurg. Society.)—*British Medical Journal*, 1st March, 1913.

Percival P. Cole, M.B., Ch.B., F.R.C.S.: The Intramural Spread of Rectal Carcinoma.—*British Medical Journal*, 1st March, 1913.

D. W. Samways, D.Sc., M.D., M.R.C.P.: The Auricle in Mitral Stenosis.—*British Medical Journal*, 8th March, 1913.

Reports on Surgical and Medical Practice in Hospitals and Asylums:—

H. B. Kent, M.B., B.S.: A Case of Super-periosteal Lipoma of Femur.—*British Medical Journal*, 1st March, 1913.

R. O. Moon, M.D., F.R.C.P.: Lecture on Angina Pectoris. Delivered at the Dreadnought Hospital.—*Clinical Journal*, March 12th, 1913.

Clifford Mayer, M.D., B.S.: Congenital Abscess of Rectum and Large Intestine.—*British Medical Journal*, 8th March, 1913.

Appointments.

R.A.M.C.

Captain H. G. Gibson, on completion of a tour of service in Malta command, has been appointed to Queenstown for General Duty.

Territorial Force.

3rd Northern General Hospital R.A.M. Corps.—Lieut.-Colonel R. J. Pye-Smith is retired, 22nd February, 1913.

Civil.

S. H. Browning, M.R.C.S., L.R.C.P., has been appointed Bacteriologist, Central London Ophthalmic Hospital.

A. R. Evershed, M.R.C.S., L.R.C.P., has been appointed Honorary Ophthalmic Surgeon, London Association for the Blind.

E. W. Routley, M.D., M.R.C.P., D.P.H., has been appointed Lecturer in Sanitary Law and Administration, King's College Hospital, London.

V. F. Soothill, M.R.C.S., L.R.C.P., has been appointed Assistant Medical Officer, Poplar and Stepney Sick Asylum, Bromley, E.

Letters from the Duke of Wellington to Sir Astley Cooper.

The Wills Librarian has recently come into possession of two autograph letters and a note from the Duke of Wellington to Sir Astley Cooper, which are printed below. These have been framed and are now exhibited in the Library.

Strathfieldsaye, Dec. 25th, 1836.

My dear Sir Astley,

I have not written to you lately, but I continue to improve, and I have met with no accident on foot or on horseback.

I see no appearance of swelling in the knee, and in ordinary times I have no feeling of a knee; but I think I feel it when I straighten it and lean my weight upon it, and the elasticity of the joint is not restored. I continue the friction with brine, and to use the bandage. I believe that these and time will attain my object at last.

Ever yours most sincerely,

Sir Astley Cooper, Bart. WELLINGTON.

Note undated.

I am certainly better. I had not been riding since Monday till this day, and I was certainly more at my case than before.

Believe me ever

Yours most sincerely,

WELLINGTON.

Strathfieldsaye, Oct. 18, 1838.

My dear Sir Astley,

You wrote to me to get a plaister, the smell of which would not be disagreeable. I wrote to Dr. McArthur as well as to Tupper. Dr. McArthur has sent me one which has no smell at all, I think less than the Poor Man's Plaister. I used some of it two or three years ago to a sprained thumb that I had. You'll see what he says of it in his note which I enclose.

I'll continue the Poor Man's Plaister, however, if you prefer it. I must get a fresh one, and have it cut so as to fit the shoulder rather better. It hangs too loose in some parts, and puckers in others.

I continue the same. I am quite well in health. I am not so comfortable as I ought to be on horseback, and have a little feel of stiffness on the left of the heel and joint. I ride a little and walk every day, and am quite strong and in better wind and condition; in short, all but well.

As far as I can judge the real object of the plaister is to keep the parts warm, and to give the joint and muscles a little support. From Dr. McArthur's account of his, and of its sticking for three weeks, I should say that it would be the best.

Believe me ever,

Yours most sincerely,

Return Dr. McArthur's letter. WELLINGTON.

Reviews, etc.

A Clinical System of Tuberculosis. Bandelier and Roepke. Translated by G. Bertram Hunt. (John Bale, Sons, and Danielsson, Ltd.) Price 21s. net.

It is somewhat of an innovation to have the various forms and manifestations of tuberculosis treated in a single volume, and the method certainly seems to have its advantages, and it is certainly logical as well as convenient to consider tuberculosis as a single pathological entity.

Chapter II. deals with pulmonary tuberculosis and seems to us particularly valuable, while the section on Treatment is nothing less than masterly. Each method of treatment is fully yet concisely studied and the indications and contra-indications in various cases. The authors show an extraordinary power of summing up previous work on the subject and presenting all that is required and no more. In regard to climatic treatment, various climates are considered with regard to their therapeutic effects. High altitudes increase the powers of resistance of the tissues and are to be recommended where the general vitality is not greatly lowered: in diabetes or albuminuria, cardiac weakness, etc., or in rapidly progressive phthisis a high altitude is contra-indicated. Low altitudes are especially suitable for slightly febrile patients with fairly advanced disease. Desert climate, sea climates, the colonies, and the tropics, etc., are compared, and also the respective virtues of various watering places.

The book is certainly a necessity as well as a luxury to all practitioners whose work brings them into frequent contact with tuberculosis. It fulfils at once the functions of text-book, book of reference, and practical guide in diagnosis, prognosis, and treatment. It is excellently printed and provided with illustrations and diagrams of great clearness. The translator deserves the thanks of the medical profession for making so valuable a work readily accessible to English readers.

Minor Surgery. By Leonard A. Bidwell, F.R.C.S. Second edition revised and enlarged. (Hodder and Stoughton and Henry Frowde.) Price, 10s. 6d. net.

Books enough have been written containing illustrations of the various small appliances of minor surgery, and we must admit to a certain impatience on first turning over the leaves of this little volume; but impatience soon gave place to admiration. It is an eminently practical book, full of sound advice, clearly and emphatically given; leading ideas and special precautions are printed in heavy type, and the book gains not a little in clearness. We would especially recommend the chapter on bandages—a subject only too little studied. The simple bandages need no description and are not described; the more difficult are explicitly explained and well illustrated. Minor operations such as circumcision, amputation of fingers, and the treatment of bone fractures and dislocations are very well presented.

Diseases of the Skin. By Willmott Evans. (Hodder and Stoughton.) Price 10s. 6d.

In the mind of the student of medicine, skin diseases are apt to be somewhat vaguely and indefinitely distinguished, and there is a paucity of books to meet his needs. What he requires is a simple, accurate, and concise description of the various diseases, a general knowledge of the treatment of the most common, and some means of impressing on his mind a picture of the complaint. And in this volume these needs are certainly satisfied. The information is short and to the point, the treatment sufficiently but not too fully discussed, and the illustrations are distinctly good. We could wish colour were employed in the illustration of the more important and more general diseases, but so far as a black and white representation can be of value, nothing is left to be desired. We should not be surprised if this book had a very large sale among students, and not only among students. Our one cause of complaint is that the frequency or rarity of the many conditions described is not, in our opinion, sufficiently insisted upon, but this is a fault common to the majority of medical text-books.

Dental Anatomy and Physiology. By Arthur Hoppewell Smith, L.R.C.P. Lond., M.R.C.S. Eng., L.D.S. Eng. (J. & A. Churchill, London.) Price 18s. net.

In this book Mr. Hoppewell Smith has provided us with another most valuable addition to dental literature. It has been compiled in such a manner that the author has made dental anatomy a most interesting and fascinating subject for the student. Being equally suitable both for seniors, students, and practitioners, this volume can hardly be looked upon as a "dry" text-book for examination purposes. It makes the study of dental anatomy a pleasure where in many cases it becomes a drudgery to those reading for their "final."

Throughout the book there are innumerable illustrations, mostly photographic and of exceptional clarity, intermingled with a copious supply of beautiful skiagrams.

Further, this work deals with the physiological aspect of the subject much more fully than most other text-books, and we are sure that the reader will appreciate this fact when he becomes absorbed in this all enthralling volume.

We specially commend the chapter on the macroscopical anatomy of the human teeth which is both concise and instructional by virtue of its representative diagrams of sections.

That part of dental anatomy dealing with the microscopical appearances of the teeth has not been embodied in this work, but is contained in another of the author's books, entitled, "Histology and Pathohistology of the Teeth," and we strongly recommend a perusal of this volume in conjunction with that under consideration.

Rugby Football.

GUY'S v. LONDON.

Final Cup-Tie.

On Thursday, March 6th, Guy's and London once again met in the Final round of the Inter-Hospital Rugby Cup. The result was a victory for Guy's by one try to nil. The Cup, therefore, remains with us for the 5th year in succession, and for the 16th time since the competition was started.

The day was beautifully fine, with a strong wind blowing almost directly across the ground. The game was preceded by the usual "ragging" scenes, in which the now famous milk can figured prominently. The Guy's supporters, along with their "fancy dressed" contingent, appeared to outnumber those of London.

When the teams arrived on the field, the multi-coloured revellers drifted to the touchlines at once, like the good sportsmen that they are.

Although winning the toss, Guy's elected to play with the sun and wind slightly against them. London kicked off; Mr. A. O. Jones, the International referee, being in charge of the game. The ball was extremely lively on the hard ground, making it almost impossible to judge accurately. For the first few minutes play was fairly even, the London forwards started off at a tremendous pace, and Guy's were once or twice seriously called upon to defend their goal line. Several offsides were given, chiefly against Guy's; and Read had two attempts at goal from long range. Broster was then conspicuous with a clever burst through, but his pass, unfortunately, went astray. London began to look dangerous, when a beautiful loose rush, headed by Roberts, brought relief; so far the game, as is usually the case in these finals, had been fought out by the forwards; if anything, Guy's had shown themselves slightly superior in the tight scrums.

The first real bout of passing came from the London backs, the ball travelled along the line and soon found its way to Stewart, the Scottish wing; but, before he had scarcely started, Medlock tackled him in great style. A few minutes later a similar movement took place, and once again Stewart found himself heavily tackled. There were several free kicks given to both sides, some of which Guy's turned to good advantage. The Guy's three-quarters next got on the move, and the ball went out to Curle, but Brown, the London full-back, tackled him before much ground had been gained, and soon after accounted for Rook in a similar way on the other wing. When hard pressed by the London forwards, Millett cleared well to half way, although previous to this he had given some anxious moments with his misfielding of the ball. The Guy's right were now getting the ball more, and yet it was evident that Davies and Broster were not quite happy with the new arrangement of places.

Medlock now tried a place from halfway against the wind, but nothing came of it. Half-time arrived with no score.

Stranack restarted the game and the London three-quarters were soon on the move. Morris kicked ahead instead of passing, and Stewart following up at a fast pace nearly scored. Hereabouts there was much kicking into touch, and London especially shone in this department of the game. London pressed and were all but over, when Batchelor kicked too hard and Millett was enabled to touch down. It was about this time that Llarena was noticed to have hurt his shoulder. He pluckily continued although obviously unfit to do so, Guy's then set up a hard attack, and when well within the London twenty-five, the ball came out of a loose scrum, a London back tried to clear and instead of finding touch, Curle was seen to snatch up the ball. For a moment it seemed that both Stewart and Brown could get to him, but Stewart hesitated and then went high, while Curle with a beautiful swerve just scrambled over the line, almost into touch-in-goal, Medlock's kick at goal failed.

With a three points' lead Guy's were given new energy, but the way London attempted to gain the lead was really wonderful to see. The tackling on both sides was terrific, the outsides could not make any ground against such stubborn defence, and much kicking was resorted to. A high punt by Medlock well followed up by Stranack and Curle just failed to bring another score; in the rush for the ball a London man just saved into touch. Llarena now had to leave the field and the Guy's "seven" played wonderfully. London were awarded a free kick well within reach for a place kick, but Stewart elected to drop kick, the ball rolling along the ground. Guy's were now doing more defensive work than attack, although play was chiefly in the Guy's half, but never very close to the goal line. Millett brought off a grand tackle of Stewart when he seemed all but clear away; it was a few minutes before the fast wingman could recover. Soon after the whistle blew for no side.

No finer defence, pluckier saving, or more thorough tackling has ever been seen. Three points is a small margin, but Guy's deservedly won, for they had a possible chance and took it. From start to finish it was desperately hard football, with no luck whatever for either side. Finally, no game has ever had a finer exhibition of refereeing than that given by Mr. A. O. Jones. Team: –

Guy's.—H. Millett (back); C. L. Curle, C. H. Medlock, G. B. Pritchard, A. F. Rook (three-quarters); L. R. Broster, J. E. Davies (halves); C. S. L. Roberts, W. S. Stranack, O. Parry-Jones, M. Tweed, A. S. Liebson, A. B. Danby, E. F. Llarena, C. G. Haynes (forwards).

Remarks.—It was good to see R. C. Mullins on the ground after so many years. No one has done more for Guy's Rugby than the old Oxford man and Hospital Captain of 1901. The team are heartily to be congratulated on their victory, especially as they finished one short. All played their very best. Curle did splendidly, and this young player, if he chooses, can most certainly be a great player in the future. Millett did many good things, and certainly saved a try against Guy's in the last few minutes, although in fielding the ball he was a little uncertain at times. The backs as a whole did well, their tackling was superb, and if only Medlock could have been back in his old position, which he has successively held in five winning Cup Ties, there would certainly have been more attacking. Roberts, Stranack, and Haynes were conspicuous in the loose rushes, and all the forwards played well, and stuck to it right to the end.

GUY'S v. OLD BLUES.

Guy's turned out in full strength for this match at Twickenham, on March 1st, and won with ease by 3 goals 2 tries to 1 try. The match was played on a hard, dry surface, and at a grand pace. It proved a very useful game for a preliminary to the stern work that was to follow on the 6th.

These Old Boy sides are made up of such good fellows that games with them are always enjoyable. A very fine pick up by Broster who sent on to Curle at once enabled that player to out-distance all opposition and score beneath the posts. Broster's immediate appreciation of the position was very clever. Parry-Jones went over with another try, and Medlock having majorised once, the second half commenced, Guy's leading by 8 points to 3, the Old Blues getting a try by the corner flag.

Throughout the second half Guy's played Medlock in the centre and Broster at out-half. The arrangement was satisfactory, though many thought it rather late to move Medlock from a position he has so long adorned. Medlock, Broster, and Curle got further tries and Medlock did the needful on two occasions, leaving the final score as above. Team:—

Guy's.—H. Millett (back); C. L. Curle, C. H. Medlock, G. B. Pritchard, A. F. Rook (three-quarters); J. E. Davies, L. R. Broster (half-backs); W. S. Stranack, O. Parry-Jones, M. Tweed, A. B. Danby, A. S. Liebson, E. F. Llarena, C. G. Haynes, C. H. Laver (forwards).

The side were very well together indeed. No need to make any suggestions as the final report will be published at the same time.

Births.

BODKIN.—On March 4th, at Tiptree, Essex, the wife of A. Malcolm Bodkin, M.B., B.C., of a son.

ASHWIN.—On the 11th March, at Waldyve House, Market Weighton, the wife of Richard Hamilton Ashwin, M.D. Lond., of a son.

Ed.—F. G. L. S.

GUY'S HOSPITAL GAZETTE.

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Passim.

A BANK-HOLIDAY in March is a doubtful benefit. From the ecclesiastical point of view Easter may come when it will, but it seems ridiculous that a holiday, intended for the betterment of the people's health, should depend for its date, and, to no small extent, for its weather, on the astronomical deficiencies of certain fourth century fathers. The reverend councillors of Nicæa were determined to make "the fourteenth day of the first month" the new moon, and Sunday coincide as nearly as possible; and hence we have the astonishingly complex table of calculations to fix the date of Easter. So long as a large portion of the working class in England dedicate their holidays to over-eating and over-drinking, rather than to some healthy outdoor exercise, it may well be doubted whether any bank-holiday is conducive to the general health of the nation; but if the Easter holiday is so timed as to preclude a reasonable probability of good weather, let us frankly include it in the ætiology of half the lesser ailments dealt with in the out-patient department.

WE are interested to note that in the early part of last month the first of a series of Surgical "At Homes" was inaugurated at St. Bartholomew's Hospital. The idea seems to have originated in the desire of London Surgeons to see the work of brother surgeons in their own and other hospitals. To stroll uninvited into each other's operating theatres would be invidious: and it was, therefore, decided to approach some prominent member of the staff of each hospital in order that he should inquire from his colleagues whether facilities could not be arranged for an interchange of knowledge which might be calculated to promote the best interests of surgery. The suggestion was very favourably received, and it was decided that once a year each of the London hospitals should arrange for an annual reception and throw open its theatres for the inspection of all the surgical staff of the medical schools The first meeting was held at St. Bartholomew's on February 3rd, the other hospitals have arranged their receptions as follows: March, St. Thomas's; April, Westminster; May, Guy's; June, St. George's; July, The London; October, Middlesex; November, Charing Cross; December, University; January, King's; February, St. Mary's.

THE lessons in military surgery of the Boer war have been strikingly confirmed by the experiences of certain French surgeons in the Balkans. Professor Monprofit lays stress on the lessened death-rate from wounds. This is due, he thinks, to three factors: to the improvement in surgical equipment and efficiency; to the packet of aseptic dressing carried by every soldier; and to the rigid observance of the rule that wounds should, as far as possible, be left to themselves and not explored, except with very special indications such as severe hæmorrhage. To these causes must surely be added the use of

the long narrow bullet, which is doing a good deal to make war more humane. It drills a small aseptic hole in the tissues, bones are tunnelled and rarely shattered, and wounds in the thorax if immediately attended close up quickly and without sepsis. But if the rifle is becoming less destructive the effect of artillery is certainly growing more terrible. The wounds dealt by shrapnel are described as "murderous"; bones were pulverized; skulls reduced to fragments, and the soft parts fearfully lacerated. On the Turkish side shrapnel wounds were 80 per cent. of the whole, and rifle wounds only 10 per cent. Among the Allies, on the other hand, rifle wounds were 80 per cent. and shrapnel 15 per cent. This explains the fact that the Turks had a greater proportion of killed to wounded than the Balkan States.

Professor Laurent, another member of the French Academy of Medicine, dealt almost entirely with cases two or three weeks old, and so was able to observe various secondary effects —aneurysms, section of nerves, etc. With regard to arterial suture, Professor Laurent does not think it feasible in military surgery. The suturing of nerves he found was performed most successfully if time enough were allowed for any septic inflammation to abate, and good results were obtained by enclosing the sutured ends in a wrapper of aponeurosis obtained either from the neighbourhood or from the fascia lata.

We received some time ago a kind invitation from the National Anti-Vaccination League to attend their Annual Meeting on March 13th. According to the invitation card they expected to have, from whatever cause, "an enjoyable evening." We trust they did.

A curious little document has been sent us from America with particulars of a new cure for tuberculosis. "I cannot resist," says the inventor "as the living example (and there are others) of a remedy, from mentioning my own case, for I suffered from the worst phases of this disease for seven years, and for over two years was an abandoned case of advanced pulmonary tuberculosis, with an abused constitution in every sense of the word . . . with large cavernous left lung." Now, however, we are glad to note that "with the exception of laryngeal trouble or a faulty heart, he is enjoying robust health." He is able to promise to prolong the life of sufferers (somehow not a perfectly satisfactory phrase) "by annihilating the cause of the disease be it tubercele (sic) or other infections, with an absolutely new remedy." If they have read "Secret Remedies," our readers will not consider this remarkable in itself; what is remarkable, however, is that it should have been sent to the Gazette!

We congratulate Mr. A. Sandison on being appointed Medical Officer to the Tuberculosis Dispensary for the County Borough of Croydon.

Appointments.

Naval.

Fleet Surgeon P. M. May, has been appointed to the *President*, additional for three months' course of instruction for S.M.O.'s at the Royal Naval Medical School, Greenwich, 1st April, 1913.

I.M.S.

To be Lieutenant Colonel, Major G. T. Birdwood, M.D., dated 30th January, 1913.

To be Majors: Captain H. B. Foster, dated 27th December, 1912; Captain S. A. Ruzzak, dated 29th January, 1913.

Commissions confirmed: Lieutenant on probation J. B. Hance, 27th July, 1912; Lieutenant on probation G. Y. Thomson, 27th July, 1912.

Lieutenant-Colonel Austin Smith, Civil Surgeon, Simla East, has been appointed to Medical Charge, Army Head Quarters Staff and Establishments, remaining at Simla during the winter.

Territorial Force.

First Home Counties Field Ambulance, R.A.M.C. C. W. Greene to be Lieutenant, dated 15th March, 1913.

Sixth London Field Ambulance R.A.M.C., Lieutenant E. P. Minett to be Captain, dated 11th February, 1913 (to remain seconded).

Civil.

C. E. Hicks, M.R.C.S., L.R.C.P., has been appointed Medical Officer to Post Office, Huntingdon and Godmanchester Districts (1st February, 1913).

Alex. Sandison, M.B., B.C., B.Sc., has been appointed Medical Officer to Tuberculosis Dispensary for County Borough of Croydon.

Some Thoughts on Orthodontia.

By W. A. BULLEID.

Read before the Dental Society.

Mr. President and Gentlemen,—In deciding to bring the subject of Orthodontia before you to-night I was moved by two considerations. In the first place, it occurred to me that orthodontia had hardly received that place in the transactions of this Society that it deserved, as representing the greatest and most modern development of dental science. Secondly, it is in itself an intensely fascinating study, and in my humble opinion the orthodontist will rank as one of the greatest benefactors of the human race. When we reflect upon the numberless cases of stunted growth and deficient mental development, which are to be met with daily, as the direct result of a deficient masticatory apparatus, with its correlated nasal obstruction, and then consider the wonderful response these cases make to orthodontic treatment, both as regards their mental and physical well-being, we are justified in saying that our profession has advanced far beyond the realms of a mere mechanical science and has made good its claim to rank with the most important, if not as the most important, branch of the healing art.

It may not be altogether out of place very briefly to sketch the evolution of orthodontia. Originally the idea was simply to obtain an even row of teeth. In all early works on the subject teeth were spoken of as being "out of alignment," and the object to be achieved was the restoration of perfect alignment. In other words, it was simply "straightening crooked teeth" to improve the appearance. No thought was given, indeed, little was known as to the proper relative positions of the teeth to one another. Later, as the result of careful observation, it was shown that there is a set and definite arrangement of the teeth in a normally developed mouth, both as regards the relative positions of the teeth and the interlocking of the cusps; and further, that any variation from this arrangement was abnormal. In other words, it was discovered that there was such a condition as normal occlusion, and also that it is only when teeth are in normal occlusion that they can properly perform their function of mastication so essential to the proper nutrition of the body. To Dr. Angle belongs the honour of first scientifically enunciating these truths and presenting a rational classification of the variations from the normal. This is a tremendous advance from the mere alignment stage of development. In the eyes of the modern orthodontist, however, the establishment of normal occlusion has come to be regarded not so much as an end in itself, but as a means to an end, namely, as the means of restoring normal developmental processes in the facial bones with the consequent restoration of normal nasal activity. This, in conjunction with normal occlusion, results not only in the normal development of the structures and functions of the internal face and the production of harmonious facial lines and contours, but in the health and welfare of the whole body as well.

It is with this broader aspect of orthodontia that I want to deal to-night. How and why normal occlusion is essential for the proper development of the internal and external face.

It is a well-known fact that the shape of a given bone is determined by the forces acting upon that bone. For example, if you examine the humerus from the arm of a muscular man and compare it with a similar bone from the arm of a woman (who is not a militant suffragist), you will find the former profoundly modified by the muscular forces acting upon it. Now let us inquire how this consideration, in conjunction with that of normal occlusion, influences the development of the facial bones. What forces mould and shape the bones of the maxillæ, and what relation they bear to the teeth.

If one examines a drawing of a transverse section of a skull at the region of the ascending ramus, one cannot help being struck by the great mass of muscle in this region, namely, the temporals, masseters, pterygoids, and tongue, and by the large area they present in comparison with that of the skull as a whole. To a large extent they surround the skull from one temporal ridge to the other, the internal ones being attached to the base of the cranium. Now all these muscles, although differing greatly as to origin, have one common point of insertion, namely, the lower jaw. The point, however, to which I most particularly wish to draw your attention is, that the fulcrum common to them all is the dental equipment, and that the forces they exert are transmitted to the facial bones through the teeth. That this is so can easily be demonstrated by slowing bringing the teeth together and noting that the muscles remain flaccid till the teeth come into contact, when they at once become tense. Now it is obvious that these forces, which are the forces of occlusion, must have a very profound influence on the development of the maxillary bones and the bones to which the muscles are attached. Now if the teeth are in normal occlusion it is quite clear, if you think of the perfect symmetry of the normal arch and the perfect interlocking of the two arches, that these forces will be absolutely balanced and evenly distributed, and hence they will stimulate and influence the development of the facial and cranial bones in a symmetrical and harmonious manner. If, however, the teeth be in malocclusion, with partial or even total loss of contact between the arches, it is evident that the occlusal forces will be unevenly distributed and cause a distortion of the bones involved. If, for instance, there

is lack of proper occlusion on the left side, the muscles on the right side only will be active, with the result that the right side of the skull will be subjected to their stimulating influence while the left side will be without such stimulation; hence the bones will develop asymmetrically, which deformity will be progressive, certainly till adult life. It should not be forgotten that this asymmetry of development affects the internal as well as the external face. A further factor, not to be lost sight of, is that a healthy and vigorous action of these muscles causes a flow of pure blood both to the muscles themselves and also the adjacent parts, including, no doubt, the brain itself.

These deductions are based upon some exceedingly interesting experiments conducted by Dr. Lawrence W. Baker, of Boston, Mass. He thought that by artificially producing malocclusion in some of the lower animals he would be able to discover what influence the disturbance of the normal occlusal forces would have on the development of the bones of the skull.

He took a litter of four rabbits at the age of weaning, killed one, and procured its skull to show the condition of the bones at that age. He then operated on two of the others by grinding down the teeth on the right side of the lower jaw and the right upper incisor. These teeth were kept ground down, with the result that occlusion was destroyed on that side. The fourth animal was kept as a check. One rabbit was killed at the age of seven months, the other and the check animal at the age of eight months. Examination of the skulls of both the maimed rabbits showed them to be twisted to the left, the deviation extending right through the skull. The right side of the lower jaw, the right condyle, the right zygomatic arch, all showed lack of development, and even the cranial and thoracic bones were affected, demonstrating the far-reaching influence of the forces of occlusion on the development of the skull, as even the bones far remote from the teeth were affected. That these deformities were the result of the malocclusion was proved by the fact that the skull of the check rabbit was perfectly symmetrical and normal in every respect. These experiments, then, throw a striking light on the tremendous influence that the muscles of mastication exert on the proper and symmetrical development of the facial and cranial bones. From this point of view the prime importance of establishing normal occlusion appears to require little further reiteration.

Having now discussed the question of occlusion in regard to osseous development, and emphasised the necessity of restoring the normal that normal development may ensue, let us turn our attention to a particular form of malocclusion and its concomitant deficient bony development, and consider in detail its pathology and treatment.

The narrow, undeveloped upper arch is a deformity to be met with any and every day, and is so familiar that its symptoms require but slight notice. The patient is almost always a mouth breather, with the result that the mouth is maintained in an open position, the lips are thick and the teeth protruding, the face narrow, the eyes having a semi-closed and quite typical appearance, the whole countenance appearing dull and heavy. The nasal passages are obstructed, and often the hearing affected, this condition being aggravated by the tongue being forced back into the throat owing to the narrowness of the oral cavity. Mentally these subjects are generally backward, and as the result of the loss of proper oral and nasal function the general health is poor.

To understand better this abnormality and its treatment, let us again consider the transverse section of the skull and study the relations of the various parts of the normal internal face. We find broad, well-developed dental arches, broad nares, giving plenty of room for the turbinated bones to function, and large, healthy accessory air sinuses. In other words, every provision for the normal and proper function of these parts ensuring continued and healthy development. The point to which I most particularly wish to draw your attention is the very close interdependence and correlation of structure of the dental arches and the superimposed structure of the internal face. The above consideration makes it quite clear that any factor interfering with the function, and consequently the development of one part, will have a concomitant adverse effect on all the others. Thus, any nasal obstruction, whether it be adenoids or what not, will, by preventing proper nasal function, cause a lack of development not only of the nasal cavity itself, but also of the correlated dental arch. Conversely, malocclusion of the teeth, with its concomitant underdeveloped dental arch will cause a correlated deformity in the nasal fossæ, the net result being improper mastication in one region and improper breathing in the other.

The importance of proper mastication is so self-evident that we will not enlarge upon that aspect of malocclusion, but will deal with nasal respiration in relation to general physical health and well-being.

The function of the nose is, in the first place, to warm and moisten the inspired air before its introduction into the lungs. No matter how cold the external air may be, by the time it reaches the naso-pharynx it is in all cases raised to approximately body temperature. Hence nasal respiration is essential for the avoidance of lung shock, and for the proper oxygenation of the blood. That the nose acts as a sifter and steriliser of the inspired air is made evident by an examination of the vibrissæ of the vestibule which shows them laden with dirt and bacteria. Bacteria that escape from these hairs are caught upon the lining mucous membrane and rendered innocuous by

the inherent sterilizing quality of the nasal secretions. It has been suggested that the slight negative pressure induced in the nasal cavity on inspiration has a considerable effect in emptying the ethmoidal and other emmisary veins, thus reducing the pressure in the longitudinal and cavernous sinuses. This factor may, I think, to some extent account for the mental lassitude so marked in these patients. Nasal obstruction means stagnation of the air, not only in the nasal passages, but also in the accessory sinuses, with consequent imperfect development of these important spaces. Put briefly, nasal breathing is a physiological process any interference with which is fraught with disastrous results on the general health and vitality of the whole system. Further, the normal development of the nasal cavities is dependent on the same process, for loss of function involves lack of development.

In the light of these considerations it is fairly clear that the ultimate aim of any treatment of the type of case under discussion must be the restoration of nasal respiration. I shall endeavour to show that this end can be best attained by expanding the arch and establishing normal occlusion.

I do not propose to deal with the technique of the operation, but rather the rationale of such treatment. Why do we expand the arch, and why is such treatment beneficial? This inquiry brings us back to the principles laid down in the first part of this paper, for both the narrow arch and the collapsed condition of the nares are but symptomatic, are, indeed, but the result of an arrested development of the superior maxillary bones, and the explanation of the condition is to be found in the fact that, owing to the malocclusion of the teeth the natural stimulative forces exerted by the muscles of mastication are wholly or partially lost. In other words, there is a more or less marked interference with those forces which normally tend to stimulate the facial bones to full development. The result is a complete lack of harmony both in the lines and contours of the external face and the anatomical arrangement of the internal. Obviously our aim should be the stimulation of these bones to renewed development and the establishment of normal occlusion that the development may be maintained. This brings us to what I conceive to be the fundamental principle underlying all orthodontic treatment, and it is this: "The osseous tissues can be stimulated to accelerated development by the proper application of artificial mechanical forces."

When the orthodontist expands the arch he practically applies this principle. He exerts a lateral stress on the crowns and roots of the teeth. This force stimulates the bone cells to an increased activity, resulting in an accelerated interstitial and superficial growth of the bones of the maxilla. This stimulation is not confined to the alveolar process, but is transmitted to the maxillary bones proper. Hence the broadening of the dental arch means a correlated widening of the nasal fossæ, resulting, not only in a restoration of normal masticatory function, but also restitution of proper nasal activity with its far-reaching influences on the general health and well-being of the patient. With the restoration of normal occlusion, and the establishment of nasal breathing, the normal occlusal forces come into play and continue the harmonious development of the whole face. Hence I think arch expansions may fairly be described as treatment for the development of the internal and external face.

In support of this contention that with a broadening of the arch there is a correlated broadening of the nares, I will cite two out of a number of cases in which accurate measurements were taken before and after treatment. They are taken from a paper by Dr. G. H. Wright, appearing in the "Cosmos" of March last.

The first is that of a boy aged 12. The incisors were in malocclusion, the laterals being locked inside the lower arch. The premaxilla was small, but the teeth well developed. Both anterior nares were collapsed and acted as valves on each inspiration. The upper arch was contracted in the region of the bicuspids. The internal nose showed approximation of the lower turbinals to the septum, which deviated above and below, making a double curve. The boy could not breath freely through the nose and with difficulty could run fifty yards without much panting and breathing through the mouth. His general condition was poor, and he altogether lacked stamina and was subject to frequent nasal colds. The distance between the antral walls below the lower turbinals before expansion was 10 mm. and after, 16 mm. That between the first bicuspids was 23 mm. before and 33 mm. after. After normal occlusion was restored the nares were in good condition as compared with their former collapsed state. The deviation of the septum was gone. The turbinals were in relatively good position away from the septum and slightly raised from the floor of the nose. There was no difficulty in nasal respiration.

Another case was that of a man of 27 years of age. He was a mouth-breather, subject to frequent colds, and altogether unhealthy. Before expansion the distance between the antral walls was 8½ mm. and after 15 mm. Nasal breathing was completely restored.

I think these cases are strong evidence in support of the assertion that arch expansion means restored nasal function.

An authority, not altogether unknown to members of this Society, objects to the use of the expansion arch on the grounds that it merely tilts the crowns of the teeth into occlusion, the roots remaining in the original crowded condition, and consequently a relapse will occur. Of course, the round arch does cause a tilting of the crowns, but the gentleman completely ignores

the fact that after occlusion has been established, the teeth are retained in position for a considerable period, during which time the normal occlusal forces are acting, with a consequent interstitial development of bone which carries the roots outwards into a normal vertical position. That this is so, observation in hundreds of cases has shown, and you can see it for yourself any day in the Conservation Room. It is quite true that a bodily outward movement of the teeth is preferable, as it largely does away with retention, and achieves the desired object more directly. There are many modifications of Angle's arch on the market that will produce this effect.

The question may now be asked: What is the most beneficial age to undertake the expansion of the maxillary arches? It is fairly self evident that as our treatment is an artificial stimulation of osseous development we may expect the greatest response at the period when the facial bones are undergoing most rapid natural growth. In the skull at birth the relative proportions of face to the skull as a whole are as 1 : 8, at two years as 1 : 6, at four years as 1 : 4, and at ten years of age as 1 : 3, while in adult life as 1 : 2. Hence development is very rapid up to the age of ten years, and we shall probably be doing our best to assist nature between the ages of four and ten, as developmental activity is then most marked. Further, the early correction of an abnormality will prevent its having any very far-reaching effect on the general health.

In conclusion, may I briefly recapitulate the principles I have endeavoured to enunciate? There are many aspects of the science of orthodontia that I have not touched upon at all. I have intentionally kept off such thorny subjects as heredity and the question of extraction in orthodontic treatment. No doubt someone more competent than I will bring them up in the discussion. I have endeavoured to confine myself to the broad fundamental principles that underlie all orthodontic treatment. I point the moral and leave you to adorn the tale.

Properly understood, orthodontia is a preventive rather than a curative science. Its aim is to assist nature when and where we see she is failing to develop along normal paths. It does not attempt to model every face to what is arbitrarily conceived to be the standard of beauty, but rather tries to develop the face to its intended type. In a normal face nature always perfectly harmonises all the anatomical parts, even to the colour of the hair and teeth. One never yet saw a bluish tooth in the mouth of a brunette or a broad muddy-coloured one in the mouth of a person of a nervous temperament. There is always a perfect balance and harmony between the shape and size of the face and that of the skull as a whole. In other words, each face conforms to an intended type, and the maximum of beauty for that particular face can only be attained by the complete and normal development of all the associated parts of that face. Therefore, it is by the restoring of normal occlusion, with its concomitant normal development, that we shall be doing our patients the greatest service both from an æsthetic and physical point of view.

You are probably by now sick to death of the phrase "normal development," but one cannot impress too forcibly upon one's mind that that is the key word to perfect mental and bodily efficiency, and as orthodontia has as its object the attainment of this condition in the most important part of the human body and in the organs that have the very greatest influence on the growth of the whole system, I claim that it ranks as second to none among the great branches of preventive medicine.

Guy's Hospital Debating Society.

THE Debate, which was held on Thursday the 13th, reminded one somewhat of a game of cricket in which both sides field.

Ten men assembled in the Club Smoking Room to consider "Whether Hospitals should or should not be financed by the State." Since it was known how four of the number would vote, great interest was evidenced as to what the remaining six would do. One, however, was the Chairman who has no vote, another snored at intervals, and showed other signs of impartiality, one other would not give himself away, so that only three were left to influence the final count. In order to allay suspense, we will say now, once and for all at the beginning of this account, that four voted for the motion, three against. By a process of subtraction we arrive at a majority of one.

Messrs. HEATON and MULLALLY, the proposer and seconder of the motion, are to be congratulated on their decisive victory.

We believe that we have seldom enjoyed a Hospital debate more than this, the last of the session. To be sure, 10 is not a great figure, but for one night in the year at least, every man had a comfortable position in front of a very warm fire. Nor was it necessary to stand up when addressing the chair. The speeches were excellent and delightfully informal. Mr. MILLER excelled himself in humorous repartee. Mr. MULLALLY was the statesman of the evening. Dr. MANN rolled out polished phrases with extraordinary ease, and made an excellent chairman. Messrs. HEATON and GATLEY spoke fluently, the latter gentleman not a little forcibly. The only thing that marred our pleasure was the refusal of Mr. PEDLEY to be drawn.

We cannot but think that when seven speakers can make a debate thoroughly interesting and entertaining, that however much the Society is "out of fashion" to-day, it cannot be long before men will turn up in dozens to take part in the debates of the future.

Notes on some of the Hospitals of Paris.

III.

The Hôpital Bichat is just outside the last station at the northern end of the Nord-Sud Railway. Its wall is built on the very edge of the rampart above the ditch of the Northern Fortifications, a few yards east of the Porte Sainte Ouen. Here I went to see the operations of Professor Hartmann. Any Guy's man is made welcome, the Professor having a great esteem for the intestinal and bone surgery of Mr. Lane. The hospital itself is among the oldest in Paris, and the crowded beds, the bottles of beer and tins of food on the lockers give the wards a very septic appearance. The theatres seemed to be well managed; no sterile bowls or dishes were used, but ordinary clean dry dishes were covered with sterile towels and used for instruments, swabs, etc.

The French surgeons wash up with great elaboration. Hartmann spends between ten minutes and a quarter of an hour over this ceremony, using soap and water, strong formalin and biniodide solution. He then puts on those thick "gardening" gloves that had a brief vogue here last year. He, like all the other surgeons I saw, does not employ a large firm at operations; on only one occasion did I see more than one assistant washed up, the exception being a hysterectomy where a third man stood by to retract. The surgeon and his assistant each have an instrument table, and, knowing exactly where each instrument will be, seem to economise time by dispensing with an instrument dresser.

The first case I saw Hartmann do was an acute appendix in a child which was brought to the table by its mother, who stood holding its hand and weeping whilst the anæsthetic was given. She then sat behind a screen until the muscles had been sewn up at the end, when she was allowed to come forward again. The operation was very quickly performed by the orthodox muscle-splitting operation, and was in all respects similar to those seen here; even my old belief that in France no surgeon bothered to bury the stump of the appendix was shattered.

The next operation was the one I had chiefly come to see. It was a "splenectomie," and I had spent a fruitless quarter of an hour in trying to find out from the theatre sister what the spleen was being excised for. The only answer I could get was that it was for "une ratte," a word I could not translate. There is a deathly silence during operations that prohibits questions, and as the patient was a man of sixty-five, I was very interested to know the reason. Two days later I discovered that "une ratte" is the spleen, and that she had explained that the splenectomy was for a spleen, just as we might explain that a hysterectomy was for the uterus. I think the patient must have had spleno-medullary leukæmia; he was very cachectic, and the spleen was enormous.

He was wheeled in by a sweating and anæmic little porter in a dirty apron, who proceeded single-handed to lift him on to the table. The patient was pretty big, and he was rather small, and it seemed probable that he would either have a cerebral hæmorrhage or drop his man. He managed it somehow.

The operation was masterly. Hartmann made a huge curved incision just below the costal margin, and was into the peritoneum in a moment. There were few adhesions, and he very quickly had the pedicle ligatured and the spleen out. He then closed the abdomen by six pieces of copper wire, which were passed through everything from peritoneum to skin, each one being twisted tight by the assistant, so that apposition was very accurate. It was an extraordinarily quick way of closing the abdomen, but I expect that for once "taking out the stitches" came up to the patient's expectations. In this, and in the panhysterectomy he did later, Hartmann showed himself to be a most able surgeon, very quick and clever with his hands, and never showing any signs of panic, although having a Frenchman's excitability to an extreme degree. His assistants occasionally receive lightning rebukes, but otherwise he never opens his mouth.

The anæsthetics here, as at other hospitals in Paris, are very much worse than any given with us; nothing but chloroform ever appears to be given, and it is always given on a folded piece of lint. Very often the patient is groaning and moving during the operation, and I have seen them reach a shade of blue that really did approach black. It was during an operation at the Beaujou Hospital that I saw the blackest individual; the chloroform was being administered by an Externe, a Russian girl doing her third or fourth year's work, and having got the patient into the last stage of deep anæsthesia she sent out the porter, who returned with a balloon of oxygen, which was squirted in the patient's face.

It is a curious sight for the English observer to see the patient come shambling into the theatre in a short nightshirt and an old pair of felt slippers; he clambers on to the table, and is immediately bound down hand and foot, and elbow and knee, to the table! The very mention of the word "ether" is met with grave headshakings and mutterings about pneumonia.

Perhaps the best genito-urinary work in Paris is to be seen at the Beaujou. The French system of combining gynæcology with the genito-urinary work of the other sex is certainly good from the surgeon's point of view. Midwifery is still kept as a separate branch, but all the diseases of women are to be seen at the Beaujou.

M. Bazy, whose father is also on the surgical staff, is another French surgeon who specially welcomes Guy's men. He was one of the first Continental

genito-urinary surgeons to visit our Department when it was established, and several times told me of his pleasure in seeing Guy's. The first time I went to see M. Bazy he was not operating, and he took me to see the hospital's Skiagraphic Department. It was curious and pleasing to find an X-ray Department where the surgeons and radiographers treated one another as colleagues. The radiographers at the Beaujou seemed to be in clover. Their cases come to them in drafted groups; on two mornings a week they see nothing but thoracic cases; on two other mornings abdominal cases; and one morning is given to bones. Three radiographers sat with me in a row in front of the patient, and a complete examination of the chest was made from all aspects. They used a very big screen, fully 4 feet by 2 feet, and the shadow was very clear. When the patients had all been seen the head radiographer showed me a number of interesting plates. Among them was one showing a bifid appendix which was subsequently removed from one of M. Bazy's Externes; another showed an opaque mass in the right lobe of the liver which had proved to be a large calculus. The differences in position of the abdominal viscera in the vertical and horizontal positions appear to be a recent discovery in France, and I felt that I was not believed when I said that we had been taught them for some years. The most admirable thing in their abdominal skiagraphy is the profile work in which they show beautifully clear views of the abdominal viscera in profile, the resemblance to the famous picture of the peritoneum in Small Cunningham being remarkable.

He also showed me a series of skiagrams of a huge stomach which were taken from someone whom he called "L'anglais MacNaughten," an apparently famous fellow-countryman of whom I was previously ignorant.

T. I. B.

Change of Address.

Percy Furnivall, L.D.S., from College Road, Nungumbaukum, Madras, to 30, New Cavendish Street, Harley Street, W.; also at 22, Elmwood Gardens, Acton Hill, W.

Leonard Myer, F.R.C.S., from 157, Sutherland Avenue, to 140, Shaftesbury Avenue, W.C. Tel. 1658 Regent.

Fleet Surgeon F. Davidson Lumley, R.N. (retired), from Lipson Lawn House, Plymouth, to No. 211, Eldon Street, Greenock.

Duncan Tracy, L.D.S., from 88, Grosvenor Road, Highbury, N., to 21, Finsbury Square, E.C.

R. M. Wormald, L.D.S., and W. J. Wormald, L.D.S., from 1, Pavilion Buildings, to 6, Marlborough Place, Brighton.

H. W. Collier, M.B., B.S., M.R.C.S., L.R.C.P., from 71, Whitehall Park, N., to 8, Princes Street, E.C. (*Teleph.*: London Wall 83), and "Kilbrogan," Dollis Avenue, Church End, Finchley, N.

Philip Turner, M.S., F.R.C.S., from 8, St. Thomas's Street, S.E., and 66, Wimpole Street, W., to 73, Wimpole Street, W. (*Teleph.*: 4457 Mayfair)

Dental Society.

A meeting of the above Society was held on Friday, March 14th. Mr. F. N. Doubleday occupied the chair. The minutes of the previous meeting having been read and confirmed, the Chairman called for casual communications.

Mr. Morrish exhibited an extremely interesting and unique volume, which he had unearthed during his recent researches in dental literature.

After the excitement had subsided, the Chairman called upon Mr. Charles to read his paper on "The Macroscopical Appearance of the Human Premolar Teeth."

The paper was very well written, and Mr. Charles is to be congratulated upon his interesting treatment of a somewhat technical subject. The numerous specimens from which he had obtained his data were handed round for the inspection of those present.

The discussion which followed suffered somewhat from the difficulty which men evidently found in keeping to the point.

Mr. Morrish, in the absence of Mr. Bulleid, thanked the reader of the paper, and then proceeded to split straws.

Mr. Neely, who followed, commenced by endorsing Mr. Morrish's remarks, and then, becoming somewhat involved, concluded his remarks by a short dissertation on the personal appearance of the reader of the paper.

Mr. Laver undoubtedly made the speech of the afternoon. Having previously examined upwards of three teeth, he rose to give the House the benefit of his researches. A small and hitherto unrecorded tuberosity which he brought before the notice of the meeting will undoubtedly ensure the handing down of his name to posterity.

Mr. Saul suggested that the name of "Laver's Cuspule" might be most appropriately bestowed.

Mr. Price Harris asked Mr. Charles whether he had met with any three-rooted premolars—a somewhat unfortunate question as one had previously been handed round.

Mr. Underwood spoke of the relation of premolar teeth to the antrum, and remarked on the absence of dental literature on the subject of the paper.

The Chairman terminated the discussion with a very able and interesting speech, and after a vote of thanks to Mr. Doubleday had been proposed and enthusiastically received, the meeting was adjourned.

Gazette Special Pathologist.

M., CLACTON-ON-SEA.—Blood serum, inoculated with this swab, gave after incubation a culture containing micrococci, including streptococci, but no Klebs-Loeffler Bacilli were found.

PATHOLOGIST

Otitic Meningitis.

CLINICAL LECTURE BY W. M. MOLLISON.

Gentlemen,—The subject of my lecture is one of much interest from a pathological and clinical stand point, and recently more attention has been drawn to the results and possibilities of surgical treatment where medical treatment holds out almost no hope at all.

I wish to consider first the *pathology* of the disease. You all no doubt have seen cases in the post-mortem room where death took place from meningitis; and you may have noticed that there are two types, one in which there is a layer of pus over the cerebral hemispheres, the other in which there is little to indicate that the patient died from meningitis except an increased amount of clear cerebro-spinal fluid at the base of the brain and in the lateral ventricles.

Let us consider briefly the anatomy of the meninges; as you know, there are three layers, the dura mater, the arachnoid, and the pia mater; the latter forms an intimate covering to the whole brain, dipping into all the fissures, the arachnoid and dura are close together, the space between them being only potential; on the other hand, the space between the pia and arachnoid is real, and it is in this position that the bulk of this cerebro-spinal fluid lies; in certain positions the space becomes extensive and the pools of cerebro-spinal so formed are given the name of cisternæ; thus there is—(1) the cisterna magna lying in the space between the medulla and the over-hanging cerebellum; (2) the cisterna pontis, and (3) the cisterna basalis lying anterior to the pons and inter-peduncular space respectively; notice that these sub-arachnoid spaces at base of the brain are directly continuous with the corresponding space round the spinal cord. One other point of interest about the arachnoid is the presence of the pacchionian bodies, those little projections of that membrane into the superior longitudinal sinus; it is through these that the excess of cerebro-spinal fluid is drained into the venous system. In proof of this assertion may be adduced the fact that coloured fluids injected into the sub-arachnoid space soon appear in the longitudinal sinus. Lastly, it is to be noticed that the cisterna magna communicates with the fourth ventricle by means of the foramen of Majendie at the lower end of the ventricle and by means of the two foramina of Luschka at the lateral part of the ventricle.

The three main sources of infection of the meninges are, (*a*) suppuration in the temporal bone, (*b*) suppuration in the sinuses opening into the nose, (*c*) infection through head injuries; of these we will only consider the first.

The results of meningeal infection are inflammation of the dura with the accompanying redness, and an abnormal output of cerebro-spinal fluid: in the first place this fluid is quite clear, and on drawing off some by lumbar puncture the only abnormality to be noticed is the increased pressure under which it escapes.

The next stage of the inflammatory process is the invasion of the out-poured fluid by leucocytes: the previously clear cerebro-spinal fluid becomes opalescent or cloudy, as seen when removed by lumbar puncture. This stage is given the name of *serous lepto-meningitis* or simply *serous meningitis*.

The third and last stage in the process is the passage into this cloudy and toxic fluid of the organisms which had brought about the inflammation; this gives rise to a condition which may be called *infective meningitis*; in this stage, too, the leucocytes increase in number, and, indeed, pus is found in the fluid, a condition of *suppurative meningitis*.

Now, though every case of suppurative meningitis doubtless passes through the stage described as "serous" meningitis where the cerebro-spinal fluid is turbid but contains no organisms, it is rare to meet with the condition clinically; the reason for this is two-fold, either the serous stage is so short that the patient is only seen when he already has suppurative infective meningitis, or the patient recovers from the serous meningitis which is unrecognised because lumbar puncture is not performed. Certain it is that recovery from serous meningitis is much more frequent than recovery from suppurative meningitis, so that from the point of view of treatment early diagnosis is of the greatest importance; and the only examination that is of much practical importance from a diagnostic standpoint is that of the cerebro-spinal fluid removed by lumbar puncture.

The normal cerebro-spinal fluid is clear, slightly alkaline, only exhibits the faintest cloud on boiling, reduces Fehling's solution, and only contains a very occasional leucocyte; the rate at which it escapes from the lumbar puncture needle is about one drop a second.

The fluid obtained from an early case of meningitis is still clear but escapes at a much greater rate from the needle; indeed, it may run out in a continuous stream and often as fast as three to four drops a second, but though this

fluid appears normally clear it is found to be less alkaline in reaction, to contain definite albumen, and to have lost some of its reducing power; that is, it has undergone some chemical change.

In a later stage the fluid exhibits the following characteristics: it is under pressure, it is opalescent, due to the presence of numbers of leucocytes which are found on microscopical examination to be polymorphonuclear, it may be neutral in reaction or even acid, and its power of reducing Fehling's solution is diminished or even gone. It contains albumen in considerable amount; on cultivation it remains sterile. The cerebro-spinal fluid removed from a case of suppurative meningitis has all the characters described above exaggerated, but on cultivation organisms are grown, and, indeed, may be found on simple microscopical examination.

Many of the organisms found in meningitis have the power of forming acid in the presence of sugars, and it has been suggested that this fact may account for the acid reaction of the cerebro-spinal fluid in the late stages of meningitis.

I wish to give you notes of cases illustrative of the three arbitrary stages I have mentioned, but before I do so let me recapitulate these stages.

(*a*) Redness of the inner aspect of the dura mater and arachnoid; *excess of cerebro-spinal fluid* which escapes *under pressure* from lumbar puncture needle.

(*b*) The cerebro-spinal fluid invaded by leucocytes, and therefore *cloudy and albuminous*, still *under pressure*; but *no organisms*; "Serous" meningitis.

(*c*) The cerebro-spinal fluid *cloudy, albuminous*, and contains *organisms*. Suppurative infective meningitis.

It is important to notice that stage *a* is an almost invariable accompaniment of any intracranial complication of ear suppuration, but that the finding of the fluid under pressure on lumbar puncture does not mean that meningitis will follow, though it is of considerable assistance in the diagnosis of the presence of an intracranial lesion. It is easy to understand how meningitis arises from a lateral sinus thrombosis, the dura mater forming the inner wall of the sinus getting infected; in the case of a cerebral abscess the meninges become adherent over an area of temporal bone, generally over the tegmen tympani or antri, since it is from these positions infection usually arises, and infection probably spreads to the meninges from the adherent area. A very frequent cause of suppurative meningitis is infection carried through the internal auditory meatus, consequent on a suppurative labyrinthitis.

The following case illustrates the first stage of meningitis:—

John S. C., aged 11 years, was admitted into Clinical on January 1st, 1912, for vomiting and headache. Six days before admission he had had vertigo and pain in the right ear; discharge from this ear followed but ceased in three days: the boy then began vomiting six times a day. On admission, patient was drowsy but had no pain, though there was a little tenderness in front of the right ear; there was some pus in the right meatus. His temperature was 97·8. He vomited several times. On the following day he complained of frontal headache and still vomited; the temperature was still subnormal; a free incision was made into the right tympanic membrane in the hope that there might be pus in the middle ear not properly drained; a lumbar puncture was performed, but the cerebral-spinal fluid was apparently normal. On January 3rd and 4th the patient was worse, and the vomiting increased; the temperature 97 or less, but the pulse 100–120. Dr. Cameron, under whose care the boy was, decided that apart from the ear there was nothing that could cause the symptoms of meningitis, and since the boy was obviously getting worse, operation was performed. On opening the mastoid antrum a few granulations were found, but no pus; the dura mater of the middle and posterior fossa was exposed but found normal. A lumbar puncture showed the fluid under distinctly increased pressure, but otherwise normal. From this time the boy made an uninterrupted recovery. Unfortunately, a cultivation was not taken from the antrum.

There are two points of interest in connection with that case, the first is that the patient was a child, and it must be remembered that a child's meninges are much more accessible from the middle ear than an adult's on account of the non-closure of the sutures and the more porous condition of the bone, also that in children meningeal symptoms arise on very slight provocation.

The second point of interest is the recovery after removal of what we must regard as the source of infection; doubtless in all cases of meningitis if the source of infection could be removed in the early stages recovery would follow as in this boy.

A second case of a very similar nature is the following, though it must be allowed that in

this case there was a fallacy in the diagnosis. Edward D., 24, was admitted to Clinical in September, 1912, suffering from severe headache. Days before admission he had been to Southend, and eaten some cockles, but apparently without ill effects. The headache had begun only a few hours before admission, and the patient was said to have had two fits when he "went stiff all over." On admission the man appeared to have the most intense occipital headache, holding his head with both hands and rolling from side to side in bed; he was extremely sensitive to touch everywhere, and seemed tender over the cervical spine, and perhaps more tender over the left mastoid process than the right; he had long standing otorrhœa on both sides. The fundi were normal. An anæsthetic was given and a lumbar puncture performed, the fluid was under very much increased pressure but quite clear, and appeared normal chemically. Dr. Fawcett was in charge of the patient, and asked me to see him. In view of the greatly increased pressure of the cerebro-spinal fluid, operation was decided on, and since the man seemed definitely more tender over the left mastoid than the right the left antrum was opened; only a few granulations were found, and the dura mater of the middle and posterior fossæ was normal. On coming round from the anæsthetic the man found he had lost his headache, and, like the boy, made an uninterrupted recovery.

The possible error there is the difficulty of the gastro-intestinal factor; it is recognised that gastro-intestinal disturbance may cause meningeal symptoms, and yet it is difficult to see why the cerebro-spinal fluid should have been under such increased tension, unless there was a condition of at least irritation of the meninges.

There is no doubt that many cases of this early stage of meningitis occur, but the condition is not diagnosed because the primary focus of infection takes the prominent place in the clinical picture, and on removing that focus the patient recovers.

To pass to the illustrative case of the second stage, the serous meningitis.

A boy, Wm. H., aged 10, was brought to the Out-Patient Department in April, 1912, on account of six weeks vomiting, and a very copious discharge from the left ear. He seemed ill, and was noticed to have very dilated and rather sluggish pupils, and was sent for examination of the eyes when Mr. Eason found very advanced optic neuritis. The boy was admitted, and a cerebral abscess in the left temporo-sphenoidal lobe was opened. The patient made a good recovery, and, indeed, went out from the Hospital and attended at the Out-Patient Department, and in July, 1912, Mr. Eason reported that the optic neuritis had entirely cleared up. In August, 1912, the patient was re-admitted for pain in the site of the previous operation, where, too, there was a small hernia cerebri; the old wound was explored but no pus found. A lumbar puncture was performed and the cerebro-spinal fluid found to be turbid; on further examination this turbidity was found to be due to the presence of large numbers of polymorphonuclear leucocytes, but, fortunately, no organisms were found on cultivation of three specimens withdrawn at different times. This condition of meningitis lead one to open the old mastoid wound very freely, remove more bone round the hernia cerebri, incise the dura mater freely, and attempt to drain the cerebro-spinal fluid by inserting gauze strips between the brain and the meninges. The boy was, during the next 24 hours, given several pints of saline under the skin, and lumbar puncture was repeated each day. In a few days the boy was well, and the cerebro-spinal fluid quite clear again. He, again, was discharged from the Hospital and attended in the Out-Patient Department. Unfortunately, three months later he had again to be admitted, and on further exploration a large abscess was found in the frontal lobe and drained, but the patient eventually succumbed, and you see his brain here; no doubt the cause of death was this small abscess, very deeply placed, separated by at least half an inch of apparently normal brain tissue from the scar of the previously opened abscess.

This boy then, in spite of the fact that he eventually died, did pass through a definite attack of serous meningitis; and I think there is no doubt that the serous meningitis would have become "infective" had not vigorous drainage been resorted to.

The striking feature of the meningitic attack was the great paucity of symptoms, some headache, slight vomiting, and the tenderness in the wound; and it was only the lumbar puncture that showed the way to the diagnosis.

The third stage, suppurative infective meningitis, is more often seen. Here is the brain of a woman who died from suppurative meningitis the other day; you will notice the layer of pus on the surface of the hemisphere and at the base of the brain; she had a cerebral abscess with very obscure symp-

toms and from the history may have had cerebral infection for some months. She had long-standing otorrhœa on the left side, and Dr. French asked me to operate; the abscess was found by following the disease in the antrum, and an abscess was opened by going through diseased dura over the tegmen antri: lumbar puncture showed fluid under increased tension and the fluid contained albumen, so that no doubt the patient had meningitis (? first stage) at the time of the operation; however, it was hoped that opening the abscess would cure the meningitis: that hope was not realised, the patient became worse, and, though a second operation with free incision of the dura was performed, she died, and the condition of suppurative meningitis you see here was found.

The following case is perhaps more instructive in being one of suppurative meningitis without any other intra-cranial complication.

A man, aged 21, was admitted to Clinical suffering from headache and vomiting. There was a condition of chronic suppurative otitis media on the right side. The headache had started six days before admission, it was very severe and was referred to the occipital region passing to the vertex. The man had vomited and continued to do so when in the ward. His temperature was 105° F. and he had had a rigor.

On examination it was found that his head was retracted, and his neck was stiff and tender; the abdomen was a little retracted, the knee jerks brisk, and the plantar reflexes flexor; there was no optic neuritis. Lumbar puncture was performed, the fluid was under increased pressure, and was turbid, it reduced Fehling's solution but contained considerable amount of albumen; examined under the microscope it was found to contain a large number of polymorphonuclear leucocytes and cocci. The man was too ill for any operative interference, and died the day after admission. The post-mortem examination showed a condition of diffuse suppurative meningitis, there was a layer of pus over the right cerebral hemisphere and at the base of the brain, and there was necrosis of the tegmen tympani clearly demonstrating the course of infection.

This case showed many of the classical symptoms of suppurative meningitis, the high temperature, the agonising headache, the vomiting, and the condition of the cerebro-spinal fluid clinched the diagnosis.

Here is another case of the same disease, but the source of infection of the meninges came from a thrombosis of the lateral and cavernous sinuses.

A boy, aged 10, was admitted on account of earache and squint. There was pus in the right ear, and a history of chronic otorrhœa. Ten days before admission earache and headache began; two days before admission he had a fit and fell, and developed a squint. On admission the boy was irritable, the reflexes were normal, and there was no optic neuritis. During the first twelve hours he was in the hospital he developed proptosis and chemosis of the right eye, the pupil became fixed, and there was some redness about the upper eyelid. Lumbar puncture discovered a fluid so full of cells as to resemble pus. The boy died two days after admission. The post-mortem showed a condition of general suppurative meningitis, and thrombosis in the right lateral sinus, the superior petrosal sinus, and the right cavernous sinus.

In these two cases the path of infection was clear, but in many cases no cause is discoverable to the naked eye; if then the temporal bone be examined microscopically inflammation will be found in the internal ear, in the labyrinth, and the path of infection can be traced through the internal auditory meatus to the meninges.

When we try to summarise the symptoms of suppurative meningitis we are met with the difficulty that the disease is so often a result of some other intracranial complication the symptoms of which mask those due to the meningitis; from this it follows that on *symptoms alone a diagnosis is often not possible.* However, the following are the prominent symptoms: headache very intense and often occipital and vertical; delirium, often marked; later coma; raised temperature, often as much as 104°F; rapid pulse; vomiting; rigors; there is seldom optic neuritis, but squint is very suggestive.

The prognosis of otitic meningitis is bad, and far worse in the late than the early stages, indeed, in the late stage—the infective stage—nothing short of operation holds out any hope of recovery, and the results of operative treatment are better the earlier in the disease that the operation is undertaken.

Recently, attention has been particularly drawn to the encouraging results of operation in the infective suppurating stage. The essentials of the operative treatment are two: the removal of the focus of infection, and drainage of the infected area. When one considers the anatomy of the cerebro-spinal spaces at the base of the brain, the difficulties of proper drainage will be appreciated. There are two positions in which the pools of cerebro-spinal fluid at the base may

be drained. 1. The cisterna pontis. 2. The *cisterna magna*; this latter may be approached, either from the posterior aspect in the middle line, or from its lateral aspect. Having decided that the meningitis arises from the ear, the course of action is as follows: the radical mastoid operation is first performed. Then drainage of the cerebro-spinal space is performed; suppose in the first place the fluid from a lumbar puncture is normal in appearance but under increased pressure, draw off fluid once or twice in the 24 hours till the meningeal symptoms are relieved.

Now let us take it that the fluid is turbid, and contains albumen and leucocytes; drainage in this case is attained by opening the cerebro-spinal space at the base as mentioned above. In practice, this can be done as follows:

Drainage through the internal auditory meatus; the internal ear is reached by performing vestibulotomy and so opening the internal auditory meatus; this method has the advantage that the bony canal provides a rigid drainage tube.

2. A decompression operation in the posterior fossa, the dura mater over the cerebellum is freely exposed by removing a large area of bone behind and below the lateral sinus, the dura is then incised and strips of gauze tucked in between it and the brain, by this means drainage can be maintained; the disadvantage of this method is that hernia of the cerebellum is apt to develop later.

3. More recently it has been suggested to drain the cisterna magna from behind through the cerebello-medullary angle, the essence of the operation is to remove a piece of the occipital bone in the middle line above the foramen magnum; the great advantage claimed for this operation is that it does away with the possibility of cerebral hernia.

The surgery of suppurative meningitis is yet in its infancy, but the results obtained by those who have had experience of these cases encourages perseverance. Early diagnosis and early operation are two essentials to success.

"Card for You, Sir."

Having to make my quarterly inspection of one of the dispensaries in my district, I have put up for the night in a stuffy little fly-haunted railway-station waiting room, and am, when the scene opens, lying on my bed, enjoying a rest and a smoke, after a hot tedious ride to a cholera-stricken village some six miles away.

It is now past mid-day, and I am pleasurably anticipating the arrival of the afternoon mail a couple of hours hence. Not so much that it means getting back to headquarters, but because I expect to travel back with the Sanitary Commissioner, who is putting up with me for a couple of days during his inspection visit. When you are the only European in your station, the coming of another white man is always more or less of an event, and when he happens to be one of your own service with whom one has many interests in common, why it is a red letter day!

"L'homme propose mais dieu dispose."

I have just dozed off, when my "khit" brings me a "chit" of soiled and draggled appearance, which I open with misgiving, for I know the sub-assistant surgeon was called out to a case first thing this morning.

Sure enough my forebodings are justified, as the gist of a somewhat obscurely worded note is that the writer wants me to come at once, as the patient has been in labour for several days, and has a pulse of a hundred and twenty—he adds that her condition "is not too bad," but my own feelings are, I must confess, pessimistic, for sad experience has taught me that my aid is, as a rule, only sought for when all hope has been abandoned, on the reasoning, I suppose, that if I can't do the patient any good, I can't do him any harm! Sound enough from their point of view, but discouraging from mine.

However, *go I must, and so enquire from the very* dense and stupid messenger how far it is, and how I can get there.

"The village is only two kos away." I express disbelief!

"The Sirkar is always right; it is perhaps nearer three," and I feel sure a few harsh words would make him confess it is four if it is a step. "Well, can a bullock-carriage go there?" "No, for the roads are very bad owing to the rains." "Well, am I expected to walk the six miles?" "No, for an excellent horse awaits the Hugoor's pleasure without." Out I go to find a huge, gaunt, disreputable-looking animal, who regards even my moderate proportions with marked melancholy. Up I clamber, not daring to put much faith in the rotten stirrup leathers, jog him in the mouth, and off we go—not at a headlong gallop, or an easy canter, or a steady trot, for he is dead lame in his off fore, and rocks like a ship at sea. A few yards of this are quite enough for me, and though his attendant swears it is only a trick, a mannerism, call it what you like, I declare that do twelve miles in this fashion I will not; and throwing my leg over his neck gracefully, slide to the ground. As I do so, a sound of rending cloth, a sensation of cold tells me that it is not my own well kept saddle that I am quitting, but one whose rusty furnishings have worked sad havoc in my attire. Realising that I am obdurate, the messenger says he thinks that after all a bullock-cart might go, and by the time I have changed my breeks, he has, sure enough, procured a "chakra." This is a conveyance peculiar to these parts, something like a diminutive coster's barrow. It has a bamboo pole, two wooden wheels, and a little platform above them about the size

of a tea tray. The driver sits on the front edge of this, with his feet along the pole, while I sit close behind on a folded blanket, my feet resting each side on the axle.

It is drawn by a couple of trotting bullocks, not the large bulky animals of the Punjab, but neat little creatures capable of getting over the ground at a good speed. A shout of abuse, a twist of their tails, and off we go. The first mile or so is over a bad "pucka" road; the stones sticking out from the worn surface create such a vibration, that I am doubtful whether I can stand it, but when nature is at her last gasp we slow down to thread our way through the Bazaar. Our passage here creates a certain amount of excitement, for a Sahib is sufficient rarity alone, but a Sahib on a chakra wrapped in a native chaddar is well worth a long gaze.

I have borrowed the driver's cotton sheet as a screen, for we are sitting right underneath the bullocks' tails, and a bullock cannot, even by his warmest supporters be called a cleanly animal.

As we rattle over the cobble stones and through the market place one sees the fat bunia sitting amongst his goods in the dim recesses of his little poky shop, for all the world like a bloated spider awaiting his prey—they are bad people these, from our point of view, ignorantly obstructive, mean, avaricious and insanitary in their habits.

Further along is a "durzi"—nowadays, hand-sewing is a thing of the past—and he is busy with his "Singer" as we pass. Next is a silversmith, not a very flourishing occupation in these parts; and after him a sweetmeat seller who is occupied in making sweets by dropping the molten mixture on his extremely dingy chaddar—well do the flies appreciate his delicacies!

Now we are passing along a narrow lane between two rows of temporary stalls, where vegetables, glass, bangles, syrups, brass goods, and all sorts of odds and ends are exposed for sale. In the middle of the "chowk" is a well, where the village matrons are busy filling their pots, but not too busy to spare a glance as we go by, and to indulge in a brief gossip as to my errand.

Rumour flies apace even in these quiet parts, and the interest they take in my mission recalls the joyful source of interest I and my little black bag were to the "mothers" of Crosby Row, in busy, happy days gone by. A sharp descent, a wet passage through the stream at the bottom, and we are outside the town among the fields of cotton and jowar. Then the track is so awful that I get off and walk, ankle-deep mud has taken the impression of the hoofs of all the animals that have passed over it when wet; and now, after a spell of dry weather, it has set like plaster of paris; its surface is such that even my blanket gets shaken off, and how the driver always manages to keep the cart beneath him when a more than usually vigorous jolt sends him flying upwards is a mystery.

As the traffic so close to the basti is considerable, the fields on each side are securely fenced off by thick thorn hedges, but after some little distance we manage to get into the fields, and then progress is comparatively smooth. It is a revelation of the possibilities of inarticulate speech to listen to the driver urging on his cattle; the favourite exclamation is a long-drawn Hee——er, but the loudness and variety of the clicks and clucks he produces with his tongue to stimulate them to further exertions is wonderful. When these fail he resorts to tail twisting and the goad. Harness there is practically none, simply a yoke which rests on the bullocks' necks just in front of the hump, with a piece of rope (which is continually breaking) passing underneath; bits, of course, there are none, and the reins are of cord.

The monsoon this year has been very satisfactory, so that the country side is a mass of green, which forms a pleasing contrast to the clear blue sky and white, heavy-looking clouds that seem so lazy and contented that they do not want to stir.

We pass a few small villages, where little naked children stand open-mouthed; splash through one or two small streams, and then the red-tiled roofs of my destination come in sight. This so excites the driver that he puts the bullocks into a canter, the result being that my attention is divided between endeavouring to preserve my precarious balance and trying to make him stop. As we jolt up the rough and rugged lane that leads to the village, my head buzzing, teeth chattering, and every joint apparently permanently loose, my thoughts fly back to a vivid account in one of the midder books—Lewers, I think—of a case where the author could not hear the fœtal heart because he had driven from the station on a frosty night in a dog-cart. I wonder whether, after six miles in a chakra, he would not have been in a condition similar to that of the deaf old gentleman depicted in *Punch* as standing in the middle of the road listening with intense interest to the roar of an oncoming motor under the impression that he hears the buzzing of a bee.

In the centre of the village the chakra stops, and I get off my uneasy perch. The husband of my patient, Gorruda, a Teli, a tall, slight man with gold rings in his ears, comes out to welcome me and give the welcome intelligence that my patient is still alive, but still undelivered. We pass into the courtyard to find nearly the whole of the village assembled there, from old greybeards down to youngsters clad in a string of beads, for this is no mere domestic occurrence, but a "tamasha," a great event which everyone has a right to share. My sub-assistant-surgeon, a stout, usually lethargic Mahomedan, is now bustling about enjoying the importance attached to his office, and comes out to tell me that he can feel the head, but is evidently not quite sure what surprises may await me at my examination. The low dark entrance to the lying-in chamber is pointed out, and one has to be careful not to trip over the sill or bump one's head against the lintel above. For a time, my vision being attuned to the brilliant sunshine outside, I can see

nothing except a dim smoky lamp, but other senses are fully occupied: the air is close and foul with the smell of stale humanity and the overpowering reek from the flaring lamp, while a persistent buzz from a multitude of flies suggests death and corruption.

Gradually, as my eyes become accustomed to the obscurity, the more prominent objects reveal themselves. My patient is sitting on the edge of a string bed covered with an indescribably filthy quilt beside which the petticoat of our Borough dames is cleanliness beyond reproach. She is supported on each side by an ancient beldame whose looks alone are calculated to depress the most stout-hearted, while at the other end of the room are a multitude of sympathising sisters, withered old hags, stout buxom matrons with children at the breast, and young girls, all alike in the keen interest they take in the proceedings.

I feel quite brutal as I turn them out and hear their protesting clatter, but the ventilation is none too free, and their presence does not make the atmosphere any purer. Examination shows pains and a presenting head, with the occiput behind, but discloses no other abnormality. I realise that a very well-marked "caput" accounts for the S.-A.-S.'s dubious half-uttered remarks anent a tumour, but I feel sympathetic when I remember the many doubts and troubles I experienced in diagnosis as an extern. Forceps are applied and the child soon extracted, but not before I have nearly dragged the patient and her two attendant familiars off the bed.

Unfortunately the child is born asphyxiated, and the most vigorous treatment produces no result. When the mother realises that the child she has gone through so much for is dead, tears flow, and she quietly sobs as she caresses the cold little limbs of the man-child she had set her heart upon, whose coming she and her husband had so longed for at home and so earnestly prayed for at the village shrine. While awaiting the placenta, I go outside and take a seat in the verandah. Its floor is cowdung plastered mud, and its supports consist of stout beams to which matting has been fastened as a protection against the rain that the strong winds would otherwise blow right into the house. In the corners and up among the rafters are a multitude of objects stored against the time they may be wanted, brass pots and pans, crazy string beds, old quilts, treasured heirlooms in the family, rusty battered lamps, old disused saddles, and cart wheels sadly in lack of repair, rickety wicker baskets, and all the lumber that the native loves to have about him, quite disregarding the fact that it all serves as an excellent home for rats and other vermin.

Outside the patient throng still squats and waits; the seductive gurgle of a hookah can be heard, but it is round the corner out of sight. To smoke it in my presence would be a breach of decorum showing that the offender was lacking in respect or more probably in knowledge of what was seemly. Out in the courtyard the shadows are growing long, the clumsy buffaloes driven in from the fields are induced at last to enter, after much suspicious snorting and tossing of their heads, and are tethered to their pegs by their diminutive attendants, while the tinkle of cow-bells in the distance has a pleasing, melodious effect.

At last I am free to go. Though I have got my tiffin basket, I dare not indulge in any tea in view of the jolting my internal economy will have to endure. My solatium is brought and poured into my bag—do not let your fancy run away with you and picture a bag of gold or rare jewels or rich Oriental stuffs! The Teli suggested the amount himself, and its equivalent in English money is about three guineas, though it makes a brave show in rupees! However, half a loaf is better than no bread, especially as I should have had to come to the rescue of my Mahomedan friend whether the patient could pay or not. Whether he would, under such circumstances, ever have been induced to leave his dispensary is another matter!

The fee question is altogether somewhat a difficult matter for the Junior Civil Surgeon; true, one never goes below a certain minimum, but when it comes to trying to fix a fair and reasonable charge for a serious operation, well, it's a hard job unless one has reliable information as to one's patient's means, for it is impossible to tell from outside appearance whether these people are rolling in money or just keeping their head above water, and, needless to say, one will get no assistance from your patient in correctly solving the difficulty.

The sun is not far above the horizon as we emerge on the level plains outside the village, and I realise that catching the evening train will be a close thing. Off we go; rattle, rattle, rattle! bump, bump, bump! hee—er, hee—er! klock, klock! shaken and jolted over the ruts till one's respect for the builder of the "chakra" is markedly increased. One feels as though one's flesh will be jerked from one's bones, and that the very teeth in one's head are working loose. No matter, we must not delay, and are doing well, until in trying a short cut the driver lands us in a quagmire, when both bullocks are bogged to their bellies, and the wheels sink nearly to their axles. It is a labour not of love, but of desperation, getting out of this ill-omened spot, and much precious time is lost before we are once more ajog.

It is practically dark as we toil up the steep ascent to the town through the dank air heavy with pollution that all who have had much to do with real India know so well. As we pass through the chorok the shops are dimly lit with small primitive lamps, whose dim light only seems to accentuate the gloomy darkness around. Ten minutes remain, we are a mile from the station, and can progress but slowly

here. However, the road soon widens, and the driver urges his bullocks to a last effort. Poor beasts, they are tired out by the bad tracks and heavy going they have experienced to-day.

We reach the station yard as the train draws up. My belongings are collected and got aboard, the servants hustled into their carriage by a guard righteously indignant at the delay, while I just have time to say good-bye through the window to a couple of native gentlemen who had come down to see me off. I then successfully search for and find the materials for a "peg," and with it a cheroot to refresh me, pleasantly reflect that dinner to-night will not be the usual solitary meal, but that I shall instead have a cheery companion with whom to exchange ideas and discuss reminiscences of home!

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—ED., G.H.G.]

DEAR SIR,—The new regulations concerning local dental anæsthetics has just come to my notice, and I think that one part at least requires some criticism. I refer to the part headed "Method for Use," where they say "that Lysol half per cent. must be applied to the gums on a pledget of cotton wool for two minutes before the injection." Surely sir, I am right in saying that a half per cent. solution of Lysol is of no real use as an antiseptic when used for a short time, and if it was used as directed for the full two minutes I think the patient would strongly object to its taste, which to my mind, is far from pleasant; especially would this be the case of a patient waiting for an extraction when the two minutes would seem at least four. Why, sir, have such drugs as Tinct. Iodine, Aconite and Iodine, or even pure Carbolic been thrust on one side? Surely any one of these are ideal, their action being almost spontaneous and their taste practically nil.—I remain, yours etc.,

Guy's Hospital. CACŒTHES.

DEAR SIR,—From observations made in discussions at the Physical Society, and from questions put to me in the course of conversation, it would seem that a considerable number of men availed themselves of the invitation to a demonstration on Bacterio-Therapeutics, recently given at a large London hospital. Such an interchange between the various medical schools of the metropolis may possibly be a valuable advance, and I have often felt some sympathy with those who find cause for wonder in the modern craze for a continental tour, whilst we remain in the darkest ignorance of the practice adopted at other schools in our own country. My point, however, is not to raise the question of the advisability of any further extension along such lines, but merely to point out to those who are interested in the clinical and therapeutic application of modern Bacteriology, that there is at Guy's a "Vaccine Out-patient Department" in the charge of one of the foremost exponents of the art, who is at the same time an enthusiastic and untiring teacher; and, further, that a voluntary course of lectures in given in Applied Bacteriology. To make this known might seem to be unnecessary, but ignorance is the only explanation I can find of the fact that of those who had sufficient of the spirit of enquiry to take them across London in the pursuit of knowledge, only two or three at the very outside have ever put in an appearance, either at Out-patients or at Lecture at their own hospital. Moreover, one who was, I believe, one of the organisers of this expedition, came to me not so very long ago after a visit to the same clinic, and informed me of the wonderful results to be obtained by the use of Tuberculin in the treatment of tubercular glands. What would be the feelings of the German Chancellor if one of the members of the Reichstag were to inform him of the excellent results of Old Age Pensions in England and suggest a trial in Germany? I think I can understand.

—Yours, etc., GORDON W. GOODHART.

Some Notes on Surgery in America.

BY E. G. SCHLESINGER.

I.

THE on-looker, dear Mr. Editor, very often sees the best of the game. He misses the hack work, and by picking the right moment is able to see the best in each place without wasting time over necessary but uninteresting details. In this country anyone who has worked with Mr. Arbuthnot Lane holds the magic key to all surgical doors, and having been privileged to see much of interest, I thought a few notes on those things which have more particularly impressed me might be of interest to readers of the *Gazette*.

In these notes I would confine myself to what I have seen in New York, and hope later, with your permission, Mr. Editor, to send some account of the excellent work that is being done at the Mayo Clinic and other clinics in the States.

Intestinal stasis is a subject holding a very prominent place in the interests of surgeons and physicians over here, and in New York has, perhaps, its most prominent advocate in Dr. W. S. Bainbridge, of whose work I have been able to see a good deal. He has operated on a very large number of cases of stasis with the same satisfactory results that we are accustomed to see at Guy's. As surgeon to the New York Skin and Cancer Hospital he has been particularly interested in the part which stasis plays as an etiological factor in intestinal cancer, and holds very strongly that the one is antecedent to the other. In operating for intestinal cancer he deals, at the same time, with the obstructed ileal termination, holding that the symptoms of the primary stasis are often as troublesome to the patient as the cancer itself.

Dr. Bainbridge has carried out some interesting work on the use of oxygen intra-peritoneally. A large number of experiments on animals showed that oxygen is readily absorbed from the peritoneum, that it is a cardiac and respiratory stimulant, that it brings an animal round quickly from deep anæsthesia, that it stimulates peristalsis, and that it tends to prevent the formation of adhesions. He employs it frequently on man and with good results, using it invariably in the operative treatment of tuberculous peritonitis. The gas is introduced through a tube at the end of the abdominal operation, the disappearance of the

liver dulness being taken as a rough guide of the quantity to be introduced. In the cases which I saw, the effects on pulse, colour, and the general condition of the patient were marked, and certainly warrant a further trial of the method.

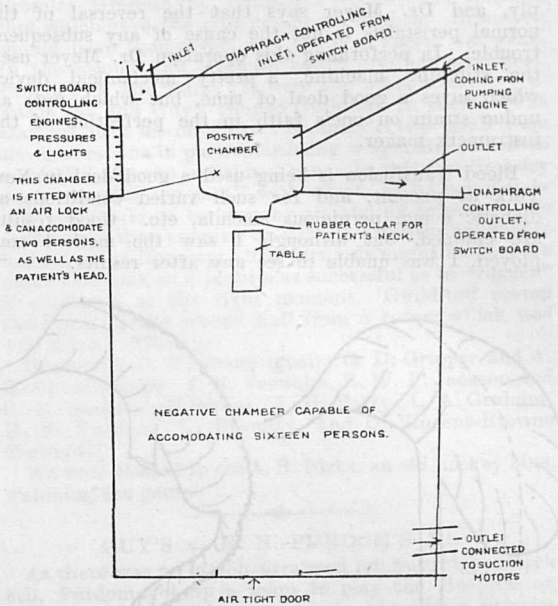
An operation which I saw Dr. Bainbridge perform on several cases is what he terms "starvation ligature and lymphatic block," for cases of removable or irremovable pelvic growths. He ties both internal iliac, both ovarian, and the middle sacral arteries, and removes the glands on either side from the obturator foramen to the receptaculum chyli. The effect of this on a growth which can be removed is, he holds, to diminish the liklihood of recurrence, while in irremovable growths, by stopping hæmorrhage the pain of congestion, and the discharge, and by allowing a free curettage to be carried out without danger, the condition of the patient is very greatly ameliorated. I have seen a number of these cases at and after operation, and the results certainly seem to suggest that the operation has a distinct field of usefulness.

Of Dr. Carrel's work at the Rockefeller Institute I hope to write at a later date, when I have had an opportunity of seeing him again.

While at the Rockefeller I met an interesting Japanese Bacteriologist, Dr. Hideyo Noguchi, who has elaborated a cutaneous reaction for the diagnosis of syphilis. He uses an emulsion or extract of a pure culture of treponema pallidum which he terms "luetin." He claims that while the Wassermann reaction is more constant in primary and secondary cases, the cutaneous reaction is more constant in the tertiary and latent forms of syphilis. Further, the cutaneous reaction is not so readily affected by antisyphilitic treatment as the Wassermann. Dr. Noguchi has also succeeded in demonstrating the presence of spirochætes in a number of cases of general paralysis of the insane.

Dr. Coley kindly showed me a number of cases of sarcoma which he is treating with his toxins. He claims to have obtained about seventy cures in some five hundred cases which he has treated. He is at present experimenting with the use of the toxins by intravenous injection, and believes that the results will be better than with the interstitial method. I hope to visit the cases I have already seen, again, in two months' time, and should be able, then, to form an opinion of the efficacy of the treatment.

Dr. Willy Meyer, one of the pioneers of intrathoracic surgery, very courteously allowed me to see some of his work, both on dogs at the Rockefeller Institute and on one patient at the German Hospital in New York. Here he has fitted up an entire thoracic block where he can operate with positive or negative pressure at will. I give a rough diagram of his differential chamber, which is so arranged that the patient's head and the anæsthetist are under atmospheric or positive pressure, while the patient's body, the operator, and his assistants are under atmospheric or negative pressure. The thoracic block also includes an ordinary operating room, observation rooms, and a separate positive pressure cabinet. In the differential chamber lights and pressures are controlled from within, and by the simple manipulation of a lever the patient can be exposed to positive or negative pressure at will.



THE OUTER CHAMBER IS MADE OF METAL, WHILE THE INNER CHAMBER CONSISTS OF A WIRE FRAMEWORK INSIDE WHICH IS A RUBBER BALOON.

DR. W. MEYER'S DIFFERENTIAL PRESSURE OPERATING ROOM.

The particular patient whom I was able to see was a man suffering from bronchiectasis, apparently confined to the lower and middle lobes on the right side, and the operation consisted in tying the branches of the pulmonary artery which supply those lobes. On account of the patient's persistent cough the operation was performed under regional and local cocaine anæsthesia. Throughout the operation a negative pressure of from 5 to 6 mm. Hg. was used, and in spite of a free opening of the pleural cavity, the lung expanded beautifully. The incision was made in the fourth intercostal space, and by retraction good access to the thoracic contents was obtainable. It was intended to ligature the artery before its entry into the lung, but the presence of glands and adhesions made this impossible, and in consequence the lobes were separated, and the lobar artery was ligatured separately. After the operation, the pleural cavity was drained through a separate incision, and the patient was placed on a bed with his head in the positive pressure cabinet, where he was to remain for fifteen or eighteen hours, a time which experience has shown suffices for the pleural cavity around the drainage tube to be shut off by adhesions. Great care has to be taken in thoracic operations to avoid undue handling of the vagus, since the majority of deaths that have occurred has been due to reflex vagus shock. So great a danger is this that the advisability of blocking the vagus in the neck with novocaine is well worth considering. Dr. Meyer has devised a very pretty operation for excision and restoration of the lower end of the œsophagus which I saw him perform on a dog. A portion of the greater curvature of the stomach is separated off, sewn into a closed tube and then, through a thoracic incision, it is pulled up through the diaphragm and united to the upper end of the cut œsophagus (Figs. I. and II.). The newly-formed tube has a good blood sup-

ply, and Dr. Meyer says that the reversal of the normal peristalsis is not the cause of any subsequent trouble. In performing this operation Dr. Meyer used the stitching machine, a pretty mechanical device which saves a good deal of time, but which puts an undue strain on one's faith in the perfection of the instrument maker.

Blood transfusion is being used a good deal in New York at present, and for such varied conditions as diabetic coma, pernicious anæmia, etc. Good results are claimed, but although I saw the method employed, I was unable to see any after results.

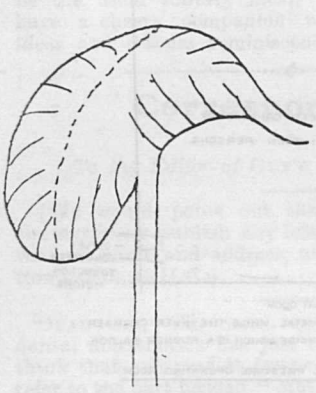


Fig. 1.
Showing incision in stomach.

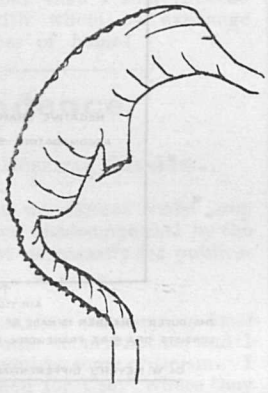


Fig. 2.
Showing formation of new œsophagus.

Dr. J. B. Walker showed me some of his excellent results with the use of the Lane plate in cases of fracture, and at the Poliklinic Hospital I shook hands with a man whose radius and ulna Mr. Lane had plated at the New York Surgical Congress.

The nursing in the New York hospitals impressed me as being altogether inferior to the nursing at Guy's. The implicit carrying out of orders, which is supposed to contribute to the ideal nurse, is carried to a ridiculous extent, and as far as I could see, the nurses in New York are assumed by the surgeons to be totally devoid of common sense. I saw one prominent surgeon order "En. Sap., to be given slowly and gently," and wondered what would happen to the house-surgeon, or for that matter, the surgeon, at Guy's who ventured to do the same thing!

Iodine is extensively used in the preparation of the skin of a strength double that used at Guy's. I was assured everywhere that iodine burns were unknown, but I saw six undoubted cases in a very brief stay.

The proverbial hustle of the American seems to apply particularly to surgeons, and rising at six o'clock in the morning does not appeal to one who has recently left the College. Nevertheless, it is pleasant to meet men to whom their profession is the great interest in life, who are not worried about the political or financial effects of Insurance Acts, who do not consider enthusiasm a disgrace, and who extend to the stranger the greatest hospitality, and invite and, apparently, even appreciate, criticism.

Reviews, etc.

Books for review should be addressed to The Editor, Gazette Office, Guy's Hospital, S.E. Their price should in every case be stated.

Diseases of the Eyes. By Devereux Marshall. (Hodder & Stoughton.) Price 10s. 6d.

This book does not profess to be a complete guide to ophthalmic surgery, but it aims at giving the student and the general practitioner a good working knowledge of the various diseases connected with the eye, and their treatment. In such a book it is impossible to avoid being somewhat dogmatic; we notice several points mentioned as facts on which there is much controversy, and a considerable literature. However such details—for they may be so considered by anyone not specialising in ophthalmic work—are not needed, and, perhaps, they are better omitted. This work certainly succeeds in being thoroughly readable and thoroughly practical. We would especially recommend chapter xviii. on colour blindness. The Young-Helmboth and the Hering theories of vision are shortly set aside, and the Edridge-Green is simply and clearly expressed. In one of the more advanced physiological examinations, perhaps, the student who retailed this chapter might not entirely meet with the approval of the examiner; but that is a small thing compared with the fact that he can present something intelligible.

The book is distinctly well illustrated and bound in the very handsome style that the London University Press has adopted for several of these text books that have been submitted to us.

Diseases of Women. By George Ernest Herman. Third Edition revised by the author, assisted by R. Drummond Maxwell. (Cassell and Company.) Price 25s.

The third edition of this important work is certainly an improvement and amplification of former editions. Previously the author contented himself with presenting, almost exclusively, methods of operation which he himself practised; but in the present edition alternative methods are described, and the book is certainly thereby increased in value. A large number of new illustrations have been added, and some very admirable coloured plates, and for the student who intends to acquire special knowledge in the subject the index of authorities will be found very useful.

The first seven chapters are devoted to a survey of various complaints often met with in practice—neurasthenia, hysteria, pain in the back, etc.—which seem to be especially prevalent in the female sex, and, therefore, are well included in the diseases of women. The chapter on neurasthenia is very clearly and suggestively written.

We welcome the arrangement of a book on a system which is clinical rather than pathological. This book seeks rather to classify patients than to group diseases; a picture is presented and we are advised to a diagnosis. In the chapter on hæmorrhage without evidence of pregnancy or new growth, we are first to consider slight bleeding without physical signs, and the mental and bodily characteristics of patients suffering in this manner. Next comes slight bleeding with physical signs—and so on. As a clinical aid in diagnosis for practitioners and advanced students the book is unsurpassed.

Nor is the pathological aspect of the subject neglected, though it is not, perhaps, presented in a manner suitable for the beginner; the plates and descriptions are very sound, and if the most recent work is not always forthcoming, what is offered is enough for practical purposes. The illustrations throughout are excellent and complete, and we should like to add a word of praise to the publishers on the printing and general appearance of this most valuable volume.

Papers by Guy's Men.

Lieut.-Col. G. T. Birdwood, M.D., I.M.S.: The Puerperium and its relation to Puerperal Fever.—*Indian Medical Gazette*, March, 1913.

A. F. Hertz, M.A., M.D. Oxon., F.R.C.P. Lond.: Bastedo's Sign: A New Symptom of Chronic Appendicitis.—*Lancet*, 22nd March, 1913.

R. W. Murray, F.R.C.S.: The Ætiology of Cysts connected with Hernia Sacs.—*Lancet*, 15th March, 1913.

John Reynolds, M.D. Brux., M.R.C.S., and Russell J. Reynolds, M.B., B.S., M.R.C.S.: On the Treatment of Carbuncles, Boils, Staphylococcic Infection and Certain Streptococcic Infection by the Internal Administration of Large Doses of Dil. Sulphuric Acid, B.P.—*Lancet*, 15th March, 1913.

Captain H. Watts, M.B., B.S., I.M.S.: Appendicitis in a Hernia Sac.—*Indian Medical Gazette*, March, 1913.

W. Hale White, M.D. Lond. and Dub.: Alimentary Toxæmia.—*Lancet* and *British Medical Journal*, 15th March, 1913; followed by in discussion

W. Arbuthnot Lane, M.S., F.R.C.S: Consequences and Treatment from a Surgical Point of View.—*British Medical Journal*, 15th March, 1913.

F. J. Steward, M.S., F.R.C.S.: Two Clinical Lectures on Calculus in the Upper Urinary Tract. — *Clinical Journal*, 26th March, 1913.

Hockey.

GUY'S v. GUILDFORD.

This match was played at Guildford on Saturday, March 1st, and after an interesting game, Guy's won by 8—1. The score suggests a very one-sided game, but actually Guy's superiority lay in Coxon's splendid goal-keeping, and the capability of our forwards to shoot. Apart from this the sides were fairly level, but in each department of the game we were just superior, at the same time Guy's never went "all out"—probably with a view to nursing themselves for the Inter-hospital final. Had we played our hardest right through we should have added several more goals to our score. We were at full strength except for Morgan and Poulton. A. R. Crowe played in place of Morgan but was off his game and did not play half so well as he had played for Guildford in the previous match against us. Purdom turned out, against orders, in place of Poulton but took things very easily and was very much out of form. The rest of the team played excellently, the halves being good both in attack and defence. The forwards were very good, too, but Bromley was inclined to "individualise" too much. It paid pretty well in this game and he got some good goals, but in the Inter-hospital match the forwards must go in for passing.

Guildford were unable to get together their usual team so they played six Sandhurst men, but this did not materially weaken them.

Four goals were scored in the first half by Graham, Bromley, Graham (2). Graham's second was a splendid shot which gave the goal-keeper no chance. Bromley's should have been saved, but the goal-keeper was weak, In the second half Graham added another good goal. Bromley (2) and Parry (1) were the other scorers. Towards the end Guy's penned Guildford in their own 25 and put in a lot of shots. Bromley's two goals were clever ones, one in particular being a splendid shot with a "flick" after an individual run. In this run Bromley used "the dummy pass" with effect, as he completely beat two would-be tacklers by pretending to pass to his centre and then running on with it after the opponents had moved to intercept. The forwards might make more use of this trick as it is quite as successful as in "rugger" if employed at the right moment. Guildford scored their goal in the second half from a corner which was well taken. Team:—

Guy's.—A. C. M. Coxon (goal); G. D. Gripper and A. R. Crowe (backs); J. F. Venables, R. W. P. Jackson and C. R. Smith (half-backs); J. H. Parry, L. A. Graham, H. N. Purdom, L. Bromley, and C. Vincent-Browne (forwards).

We were pleased to see A. B. Birks, an old hockey blue, watching the game.

GUY'S v. H. N. PURDOM'S XI.

As there was no match arranged for Saturday, March 8th, Purdom got up a team to play the Hospital on Monday, March 10th, in order to give them practice before the Final on Friday.

The game was played at Richmond, on the ground on which the Final was to be played, and would have been a pretty good one had Purdom's full team turned up. Unfortunately, however, three of the best men failed him at the last moment. Bond also scratched on Monday morning, and it was only with great difficulty that one substitute could be found. Purdom himself also played, and this brought the total up to 9. We borrowed Coxon from the Guy's team to make the sides level. The weather was very cruel as it rained practically all the time, and this prevented any very good stick work. In fact the whole display of hockey was not good, but it gave the Guy's men plenty of practice and this was the main thing. Martin opened the scoring for Purdom's team, and for some time the sides seemed fairly level. However, there were two or three "rabbits" in the scratch team, and this threw so much work on the hands of the others that they were soon tired. At half-time Guy's led by 3—1, and they finished up with a win of 8—1. Teams:—

Guy's.—O. G. Morgan and G. D. Gripper (backs); J. F. Venables, R. W. P. Jackson, and C. R. Smith (halves); J. H. Parry, L. A. Graham (capt.), E. P. Poulton, L. Bromley, and C. Vincent-Browne (forwards).

H. N. Purdom's XI.—A. C. M. Coxon (Guy's) (Goal); C. M. Higgens (Sussex), and B. Burnside (Guy's) (backs), F. B. Biddle, H. N. Purdom, and L. Waghorn (Guy's) (halves); A. R. Crowe (Guy's), J, R. Campbell (Croydon H.C.), R. E. Higgens (Hastings H.C.), and J. N. Martin (Guy's) (forwards).

INTER-HOSPITAL HOCKEY TOURNAMENT.

Final Round.

GUY'S v. BART.'S.

This match was played at Richmond on Friday, March 14th, and after a very fast game Guy's won by 5–0.

Guy's have now won the Tournament ever since it was introduced, in 1904–5, *i.e.*, eight years in succession.

This year it was a stern struggle, and Guy's had to fight against misfortune, too. The semi-final against London —the strongest of all the hospitals except Guy's—had to be played twice. In the first, J. H. Parry was ill, and H. N. Purdom was crocked in the first 10 minutes, Guy's having to play the rest of the game, including 20 minutes extra, with only 10 men. In the second, Parry was still crocked, and Venables was playing his first game for over 6 weeks. It was a tremendous experience for the latter to have to play an extra 40 minutes to a game which was exceptionally fast, and when he had had no training. But we pulled through all right, and now feel very triumphant on once more winning the tournament.

Our record of Inter-Hospital matches is as follows:—

1st round	v. King's College Hospital,	won.	7—1
2nd "	v. London Hospital ...	drawn.	3—3
Replay	v. " " ...	won.	3—1
Final	v. St. Bart.'s " ...	won.	5—0
		Total	18—5

The weather was dull and this may have affected the attendance a little, but happily rain kept off. We were very pleased to see Mr. and Mrs. Steward, and Mr. Fagge present.

The team was photographed before the game—against the advice of some people who superstitiously declared that we should lose the match after this. No evil result came of it, however. Guy's started off down hill and for some time both teams played rather wildly. There were several mis-hits. However, the men settled down and both sides attacked in turn. Coxon saved very well once, but other shots went wide. The same happened at the other end, where both Graham and Poulton missed pretty good chances. Finally Graham scored a goal, rather luckily, as he would have been off-side but for the ball touching an opponent. It seemed as if the goal-keeper might have stopped the ball as it went between his legs. However, it was going very hard.

No further score resulted before half-time. On the resumption Guy's made several mistakes during the first 10 minutes. Several of the men were missing the ball altogether, and Coxon had several exciting moments which he passed through with great credit. Then Guy's got together again, and after some very pretty passing between the inside forwards, Poulton scored a good goal. A few minutes later Parry put in a magnificent shot from a very difficult angle. Just after this Parry was cut over the eye by a jumping ball, and Mr. Fagge took him over to the Richmond Hospital to have a stitch put in, Guy's continuing with 10 men.

This did not seem to affect the forwards, however, who were now playing brilliantly. Bromley took the ball from half way, and after running right through the defence, finally scored with a clever flick shot. Finally, there was another round of passing, and Poulton scored the fifth and last goal, Guy's winning, as stated, by 5-0. In the evening the members of the victorious team were the guests of Mr. Steward, the President of the Hospital Hockey Club, at the Trocadero. The dinner was much appreciated and at the end Toasts were drunk to the King, proposed by Mr. Steward; Guy's Hospital Hockey Club, coupled with Mr. Steward, proposed by Graham; and the Captain of the Hockey Club, proposed by Mr. Steward. It was a very enjoyable evening.

Season's results: Played 19, Won 12, Drawn 3, Lost 4; Goals for, 91; Goals against, 35.

This is quite the best record we have had lately, and, had we been able to turn out our full team, it is fairly certain that we should have lost none, and two, at least, of the drawn games would have been wins.

It is good to see Hockey up to such a high standard now, and we hope that next season players will be keener than ever. A strong fixture list has been arranged, and it is hoped that we shall succeed in getting fixtures with the 'Varsities.

At a "Blues" Committtee Meeting during the season it was decided to award a full blue for Hockey in future, to date from this season.

While writing this there comes the news that Guy's have again won the Inter-Hospital Cross-Country run.

Three good wins for Guy's:—Rugger, Hockey, and Cross-Country.

Goal scorers during the season:—

Graham	... ...	19 in 10 matches.
Bromley	... ...	16 " 12 "
Poulton	... ...	16 " 11 "
Vincent-Browne	...	10 " 19 "

Other scorers:—Parry, 7; Jessop, 7; Peregrine, 4, etc.

Gripper, Jackson, Smith, and Vincent-Browne have been very keen each only missing one match. Parry and Purdom have missed two each, not counting Inter-Hospitals. Coxon, in goal, has been brilliant throughout.

The Inter-Hospital Cross-Country Challenge Cup.

The annual Inter-Hospital match was run on Saturday, March 15th, starting from the "Green Man Hotel," Blackheath, the Blackheath Harriers' headquarters. Guy's and London were the only Hospitals to send teams. The course was about 7½ miles. The result, thanks to the fine running of J. R. Barrow-Clough and A. G. Forrest, ended in a win for Guy's, the score being 14—22, Guy's thus holding the cup for another year. The officials were:—Judges, Dr. Munro (President) and J. W. Beacock. Timekeeper, E. Ratcliff. Details:—

	Mins.	Secs.
1. W. K. Fry (Guy's)	44	5
2. J. R. Barrow-Clough (Guy's)	44	9
3. A. G. Forrest (Guy's) ...	45	1
4. G. R. Sharp (London) ...	45	15
5. A. D. Stammers (London)...	45	25
6. J. F. Twort (London) ...	46	26
7. A. Ll. Evans (London) ...	46	56
– H. C. Billings (London) ...	47	25
– J. W. Hyatt (London) ...	47	27
8. E. H. Bryant (Guy's) ...	48	25
– A. W. Willatt (London) ...	also ran.	
– A. V. Deacon (London) ...		

W. K. FRY, Hon. Sec.

Births.

ACHNER.—On February 24th, at 90, Highbury New Park, the wife of Conrad A. Achner (*née* Tuck) of a son.

ALLAN.—On March 19th, at 10, Beauclerc Terrace, Sunderland, to Mr. and Mrs. Douglas Allan, a daughter.

DENSHAM.—On March 11th, at 50, North Gate, Regent's Park, the wife of Mr. Ashley Densham (*née* Cheesman) of a son.

SMART.—On March 12th, at Clifton House, Shelley, Huddersfield, to Dr. and Mrs. H. D. Smart, a son.

BOX.—On February 6th, at Bridge House, Stratford-on-Avon, the wife of William F. Box, of a son.

Ed.—F. G. L. S.

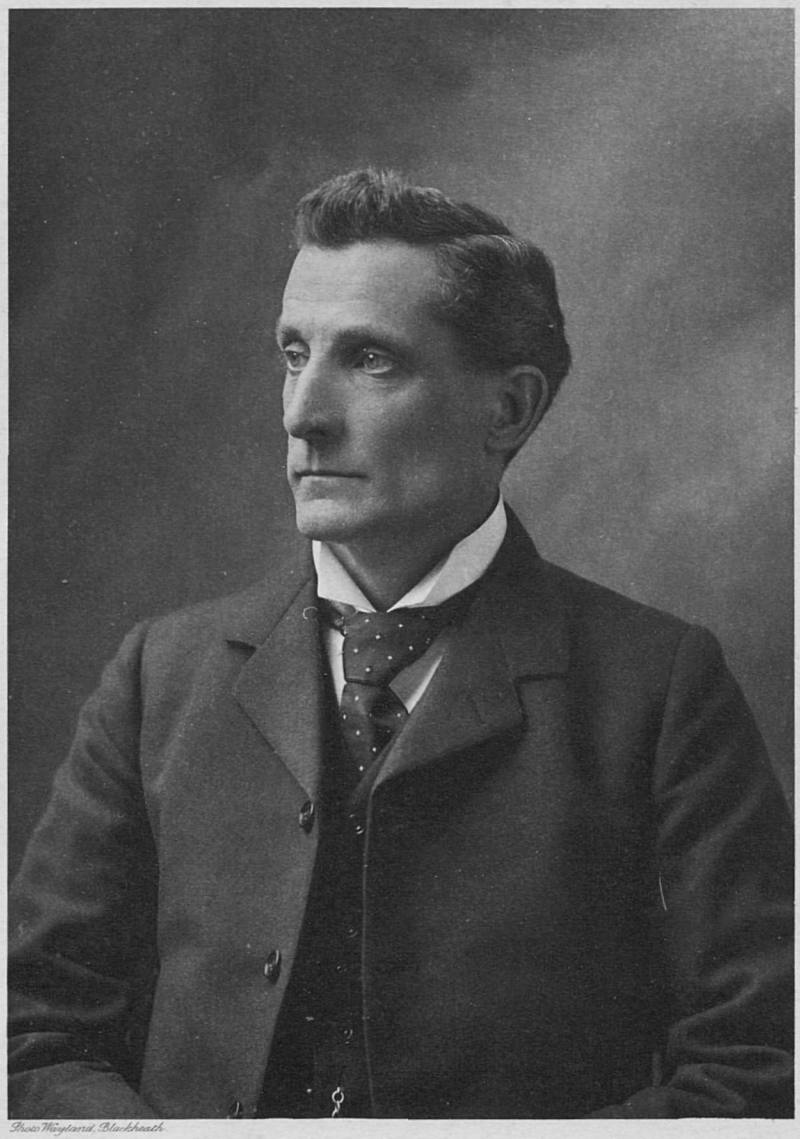


Photo Weyland, Blackheath

Yrs sincerely
J. H. Garrett

GUY'S HOSPITAL GAZETTE.

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Obituary.

A. L. GALABIN,

M.A., M.D., F.R.C.P.

IN the death of Dr. Galabin, not only has the Consulting Staff lost a great man, but the profession a man who, in his day, was a leader of world-wide renown in the branch of obstetrics.

He entered Guy's in 1869—having completed the required medical curriculum at Cambridge, and was at first a puzzle to his fellow students; for with his mathematical honours thick upon him (he was a high wrangler), they asked among themselves, as the writer well remembers, what use can a profound mathematician be in a profession, the very essence of which is practice, and not theory?

Galabin's life may be said to have been an unconscious refutation of this doubt; and he showed that the cast of mind that makes the mathematician may yet be moulded to meet practical, and highly concrete instances.

When appointed to follow Dr. Phillips, as second to Dr. Braxton Hicks in the obstetrical department, one of his first acts was to devise, after a profound mathematical study of Carus' "Curve," a pair of obstetric forceps—the only instance, as far as the writer remembers, of applied mathematics that Galabin ever perpetrated.

He now plunged at once into practical matters, and with a view to subsequent publication, began the microscopic study of the tumours peculiar to women; and many were the evenings that he and the writer conned over the carefully prepared microscopic slides in their rooms in Saint Thomas' Street. What struck one then was that Galabin would take nothing for granted, but although he was versed in all that was written on the subject, he verified with his own hands and eyes every minute particular.

Whether the extreme precision that characterised all he did and wrote was the outcome of mathematic training, or part and parcel of his own personality, it may be hard to say; but his attention to minutiæ not only appeared in all his work which was of the highest scientific value, but unconsciously (one feels sure) was exhibited in his medical practice, whereby he became not only an exact diagnostician and physician, but could interest himself in the smallest matter that concerned his patients. This interest extended to the moral side of his work, and enabled him to show in detail that true sympathy which his clientele so valued, and

which, added to his kindness of heart, made him so universally beloved. It mattered not on what one talked, Galabin, heart and soul, at once entered on the subject, put himself intimately in touch with his companion, whilst the merry twinkle that showed in his eyes removed the feeling of restraint that his usually abstracted and meditative expression might otherwise have engendered.

Thinking of his appearance one might say, with but little exaggeration, that Galabin hardly looked a day older when he retired from work than when he entered Guy's as a student; whilst his quiet, gentle, retiring manner, out of place, perhaps, in a student, never altered, and fitted him well in his later years. Courteous to all, a perfect gentlemen, keenly sympathetic, of gentle voice, he possessed all the essentials for success in the practice of the particular branch of medicine that he took up. Such qualities must have made him a favourite with his patients, even if his great and manifold attainments had not raised him to the high pinnacle of fame that it was his lot to reach.

He began the work of his professional life in the drawing-room floor of the house in St. Thomas' Street, then No. 14, next to, and on the west of, the brick archway of the house, still, I believe, occupied by our nursing institution. The lower floor was occupied by just such another as Galabin himself, in courtesy and kindly behaviour—Mr. Le Gros Clarke, Consulting Surgeon to St. Thomas's Hospital—and there existed between the two men a great friendship for the short time that the latter was spared. On his death, Galabin took the whole house, married, and carried on his consulting practice till his removal to Wimpole Street, where he remained till his retirement to Devonshire a few years ago.

On the Staff of Guy's he followed, in due course, Dr. Braxton Hicks as senior obstetric physician, but long ere that he was an authority on his special subject, and had brought out his Manual of Obstetrics which became world famous. It was a book, however, that the writer remembers the student of those days did not love; for he did not—he could not—often appreciate it. It was such a complete précis (without, however, any omissions) of the subject, so minute were its details, its sentences so pithy and weighty, that it required, to comprehend it, a clearness of brain, not always to be found in Maze Pond.

Besides his "Manual of Midwifery" and "Diseases of Women," both of which passed through several editions, he was the author of many contributions on cognate matters, and on one, which, by the bye, was not so nearly related to gynæcology: for in his earlier years he was much interested in, and worked a great deal with, the newly-devised sphygmograph. About this time also he was on the Staff of the Ormond Street Children's Hospital, but he did not combine the practice of children's diseases with that of gynæcology to any extent, as was rather the fashion in those days.

He did not shirk academic drudgery, for he was frequently on various examining boards, whilst it goes without the saying he was in due course elected to the Presidency of the Obstetrical Society.

When at last he felt that he might fairly claim relaxation from the strain of professional life, he retired to Tapley Court, at Bishopsteignton, a beautiful property (which he had been able to acquire, and with which he had some very early associations), where, in the quiet of his old-world garden, he occupied himself in many ways. Always fond of a Swiss holiday, he had acquired a number of plants, and these he fondly cherished in his alpine garden, whilst the introduction of shrubs from abroad, and the endeavour to acclimatize them to the mild Devonshire air was a constant source of pleasure.

It is but two years ago that the writer, a fellow student of Galabin, had the pleasure of enjoying the hospitality of Dr. and Mrs. Galabin; and the memory of the kindly figure slowly moving about his rose garden, administering insecticides and what not, with professional judgment and care as though the plants were old friends and patients; of the cheering sympathetic nature that showed in every action and beamed from kindly eyes, will always be present as a very happy mental photograph of a dear old friend.

Passim.

THE death of three of the Governors within a week is, we believe, an experience that has not fallen to the lot of the Hospital before. It is our painful duty now to record that fact, and we do so with sincere regret.

In Mr. Robert Barclay the Governors lose their senior colleague, his election dating as far back as 1864. The family have been connected with Guy's for very many years, his grandfather, Mr. Charles Barclay, having filled the office of President from 1848 to 1856. To all with whom our late Governor came in contact he ever showed himself kind, courteous, and benevolent, with a consideration for others as rare as it was charming. And we cannot fail to remember how much the Hospital has been indebted to him and his firm for unobtrusive assistance during the time of its great financial anxiety.

The Earl of Pembroke & Montgomery, elected a Governor in 1898, though not much seen at Guy's, was interested in its welfare. It is only a few years since that he was good enough to come down and preside at the Annual Prize-giving of the Medical School.

In Mr. Pierpont Morgan the Hospital loses a Governor of 23 years' standing, during which time he, together with his father and his intimate friends, has shown a munificent liberality towards the Hospital, which has been truly and deeply appreciated by the Authorities.

Let us hope that worthy successors may be found to carry on the traditions of their predecessors.

THE death of a millionaire affords an occasion for the emission of a thousand platitudes upon the unequal distribution of wealth. Everybody is inclined to suggest that the anomaly of exceptional riches is inconsistent with the welfare of mankind. The obvious answer is of course this that redistribution is only a theoretical possibility, for such are the changes and chances of life, and such the diversity of characters, and abilities that redistribution could be no sooner effected than it would have to be repeated, and repeated again. Let us, however, suppose the impossible to be possible, and assume an equity of possessions—every man to be as rich or as poor as his neighbour—and let us endeavour to forecast the results of such equality upon the methods of charity.

It is plain, in the first place, that there would strictly be no place for charity. My neighbour having as much as myself, there would be no scope for mutual consideration and compassion, and such feelings would tend to die out. In their place there would arise a system of insurance against sickness and accident, since this inequality, at least, would remain whatever precautions were taken against it.

Such a mechanical provision for the eventualities of life would be solely of the nature of a prudential arrangement. The Angels of Mercy and Charity would be superseded by Dame Prudence—but would this most estimable lady be qualified to do angels' work, and would she do it in the angels' way? There are spheres in which the business faculty reigns supreme, and in which we can do without sentiment, but it is questionable whether the former faculty is suited for clinical ministration. Faith-healing has, at least, taught us that something more is needed for cure than the knife and the medicine bottle. The human element is as important in the ministrant as it is in the patient; and it may be doubted whether it could be supplied without the presence of emotional impulses. The cup of cold water is not mentioned in the pharmacopœia, but there can be no doubt that it is a potent restorative. It can only avail when it is drawn from the well of charity. It cannot be had for the asking. It is not customary to parade the deeper feelings, but their presence, though, perhaps, unconscious to the individual, is of no small importance. The prescription is often of less potency than the prescriber. Anything that would tend to discourage sentiment would be detrimental to the highest interests of our craft.

We may notice in the next place that the ideas of small men are small. Great institutions, such as our Hospitals, cannot be adequately conducted by those whose experience of affairs has been confined to repairing the parish pump. Such limited spheres afford little scope for the

exercise of imagination, and imagination is essential to success. The big man alone can see the big things, and can alone carry them to operation. Now, millionaires may be either good or bad, but whatever they are, they are big. They occupy a position of immense influence, and, rightly used, such influence is of untold value. They can initiate great movements, and their beneficence encourages the efforts of the comparatively poor. The wealth of the world is a constant quantity, but we may doubt whether the world's welfare would be secured by this wealth being evenly distributed. The law of averages would not produce good results if applied to intellectual endowment. There would be no clever men if all men were equally clever, and it may be that there would be little progress if all possessed an equal property.

It is often supposed that great fortunes are a fraud upon Society. If they were hoarded in the safe they would be such a fraud, but they are not hoarded, but dispersed, and perhaps dispersed to better advantage from being temporarily placed in the hands of such as have still to adapt them to wide ends. This good purpose may sometimes be served even despite the possessor, just as the money of the wastrel may be in effect as productive of eventual good as the money of the charitably inclined. But how great is the benefit when, as in the case of our late Governor, the means of doing good is accompanied by the desire, even the passion to do it! Such wide-reaching generosity is an example of the best use of wealth, and a sign that the life even of a millionaire is incomplete and unsatisfying without the display of those simple virtues which are the duty and the happiness of every good man.

The Royal Society of Medicine held a meeting on April 1st at Guy's. The New Pathological Department was thrown open to inspection, and we were glad to hear many remarks testifying to the excellence of the scientific equipment of the buildings. Of the papers contributed we note in every case the author was a Guy's man, and that in all but one the work had been carried out at Guy's. It cannot fail to be gratifying to the anonymous donor to whose generosity we owe the new Pathological Buildings to have such substantial proof that valuable work has been accomplished in so short a time.

It is with very great regret that we record that Miss Henry is now closing her Home, which has been open to Guy's patients for over twenty years. Miss Henry, at one time a Lady Pupil and Sister at Guy's, opened the Home, at 6, Heene Parade, Worthing, in February, 1893, for the reception of eleven women and children, patients of this Hospital, furnishing and maintaining it entirely at her own expense. During the last fifteen years, for which exact figures can be obtained, 2,272 patients have been sent there, an average of over 150 a year, the only expense to the Hospital being the railway fares. The Home faces the Sea, and the drawing-room, which Miss Henry gives up to the patients, has a large covered balcony overlooking it. Fires in bedrooms, early cups of tea, breakfast in bed, are among the luxuries afforded them, and it is no wonder that one old woman writing from the Home to the Hospital said "it is the land of Beulah." Miss Henry takes cases requiring surgical dressings, and these, and all nursing, she has done herself. And above and beyond all this is her power of understanding her patients, of entering into their lives, and discovering where the real trouble lies, and to very many whom she has thus learned to know she has continued her sympathy and help for years after their stay with her. To be sent to "Miss Henry's" has always been the desire of Guy's patients, and certainly she will not be forgotten. It is impossible to say how much the loss of this Home will be felt, for devotion and kindness such as hers are not likely to be met with again in a life-time.

As we go to press, we hear that Mr. Arthur J. Balfour has promised to perform the ceremony of opening the completed School Buildings, on a day early in May.

The work of re-building the Medical School has been steadily pursued during the last ten

years, and has now, with the erection of the Departments of Chemistry, Physics, and Pathology, and with the extension of the Dental Department, reached completion.

Such an occasion as we shall witness next month comes but rarely in the history of any School. In 1890 the College was opened by Mr. W. E. Gladstone, at that time one of the oldest Governors of the Hospital; and in 1897, the first block of the present Medical School Buildings was opened by his late Majesty, King Edward VII., at that time Prince of Wales, and President of the Hospital. Now that the whole scheme has been completed, and the School is possessed of Laboratories second to none in London, the occasion must be marked as, perhaps, the most important in the whole of its history.

We are sure that all Guy's men will unite in giving a welcome to Mr. Balfour—also a Governor of the Hospital—no less warm than that which was accorded to his distinguished predecessors, King Edward VII. and Mr. Gladstone.

F. G. L. S.

Change of Address.

R. Davies-Colley, M.C., F.R.C.S., from 48, Brook Street, W., to 30, Weymouth Street, W.

George Evans, M.B. Lond., from Bexley Asylum, Kent, to Severalls Asylum, Colchester (on May 7th).

E. L. Elliott, M.B., B.S. Lond., from Willow Tree House, Otford, Sevenoaks, to Bayham Road, Sevenoaks.

R. Manton King, L.D.S., from Guy's Hospital, to Havercroft, Chapel Road, Worthing. (*Teleph.* 102).

G. Marshall, M.B., B.S., from Guy's Hospital, to 38, St. Mary Abbott's Terrace, Kensington, W. (*Teleph.* 417 Western).

W. M. Mollison, M.C., F.R.C.S., from 48, Brook Street, W., to 9, Upper Brook Street, W. (*Teleph. as before* 6997 Western).

Major H. D. Peile, I.M.S., to 52nd Sikhs, F.F., Bannu, N.W.F.P., India.

Arthur Zorab, M.B., B.S., from 7, to 21, Carlton Crescent, Southampton.

L'anemie des Enteritiques.

By Prof. M. LOEPER, Paris.

Anæmia is not rare among patients with enteritis, either acute or chronic, whether the patients be young or adult. This anæmia is usually met with in certain cases of choleriform enteritis when microscopical examination shows the presence of bacilli resembling coli b., paratyphoid, perfringens, and enterocolic bacilli, and it may rapidly fall to 2,500,000 or even to 2,000,000 red corpuscles. It is rather frequent in torpid intestinal conditions, muco-membranous enteritis, intestinal dyspepsia, typhlatony, or typhlectasis, and then occurs in intermittent attacks appearing at the same time as an increase in the intestinal symptoms.

This anæmia, connected both with hypohæmatæmia and with hypohæmoglobinæmia, is frequently accompanied by subicterus, arterial hypotension, urobilinhæmia, but not by choluria; the spleen is often hypertrophied, and there may also be an increase in the size of the liver. One may easily understand why anæmias which have their origin in the liver with intestinal troubles and abdominal pains should be often mistaken for liver attacks since both are characterised by the same discoloration of the skin and by an almost exactly similar localisation of the pains.

Vomiting, however, as well as the pains spreading towards the shoulders, and the urinary pigments are generally absent, and the condition is improved, not by treating the liver, but by treating the intestine, a point of the utmost importance. The examination of the stools reveals a slight insufficiency in the transformation of protein. The bacteria most frequently found are, as already stated, *perfringens*, *enterococci*, and coliform bacilli.

If we try to investigate the nature of these anæmias, we clearly realise that they are the result of a hæmolytic process. Still, the resistance of the corpuscles is generally less, the auto-agglutination of the red corpuscles is absent, but the increase in the hæmolytic power of the serum is almost constant. The hæmolysis is, therefore, the result of an exaggeration in the destructive power of the serum towards the red corpuscles, and not of a weakness of the red corpuscles themselves.

If injected to rabbits, the serum of anæmic enteritic patients very often causes a diminution in the resistance of the corpuscles, and almost always a fall in the number of red corpuscles, this fall being much greater than with normal human serum.

The hæmolytic substance is also hypotensive since these patients have always a tension below normal. It passes in the urine, since the sediment of the urine experimentally produces hypotension and anæmia.

This substance, which is certainly organic, seems to be produced in some cases by the ferments which are absorbed all along the alimentary canal; in other cases

by bacteria, namely, perfringens and coli, the hæmolytic action of which is well known; in other cases, again, by the hypersecretion of the intestinal cells, or even by their destruction.

No doubt the bacteriolytic products play a prominent part in cases of acute enteritis; the products of a cellular origin, the cytolysins, have an importance which seems to be greater in chronic cases.

If extracts of the intestinal mucous membrane, and especially of the mucous membrane of the ileon and and colon, are injected to animals, a distinct anæmia is produced, and the hæmolysing action of these extracts is increased by addition of pancreatic ferments. Therefore the absorption by the inflamed human intestine of pancreatic ferments and of intestinal products is an important factor of hæmolysis.

In its normal condition, the liver prevents the hæmolysing action of all these substances, but its stopping function is greatly disturbed in enteritis.

Of the above expose leads to the following practical rules in the treatment of enterogenous anæmia: disinfection of the intestine, even with lactic bacteriotherapy and aperients in small repeated doses; strengthening of the powers of the liver by salts of magnesia; increase in the resistance of the blood by lipoids and regeneration of the blood by calcium and iron products.

Comment doit on prescrire le bicarbonate de soude aux gastropathes ?

By Dr. E. BINET, Vichy.

Only moderate doses of bicarbonate of soda must be given; the dose of one drachm and a half is the maximum daily dose. Under such conditions the patients to whom this salt must be prescribed are those affected with disorders of gastric evacuation, and whose stomach empties itself too slowly. Late evacuations are met with in two cases and characterise two conditions. In the first case, owing to insufficient peristaltic contractions, the churning of the alimentary mass is too slow and insufficiently stimulates the opening of the pylorus; in the second case, the muscle has retained its normal tonus, but the contractions which it causes, however strong they may be, are only able to overcome very slowly the spasm which keeps the pylorus closed. In the first condition, the diminution of the secretion, hypopepsia, is parallel with the muscular atony; it is the condition of its evolution, and its very degree enables us to evaluate the degree of the gastric hypotonicity. In the other condition, on the other hand, hyperpepsia is generally present, and the higher its percentage the easier and the stronger is the reflex occlusion of the pylorus.

Clinically, gastric pain in itself seems to be a sign of abnormal evacuation, whatever be its form in the course of digestion or its conditions of time and duration.

For all these reasons bicarbonate of soda is indicated in a great number of cases. Except in cases when there is an acute ulceration (hæmatemesis or melæna) and except in some cases of gastric cancer, its use may be freely recommended. It must be considered not so much as giving an immediate and temporary result, but as a regulator of gastric digestion. Therefore, it must be given to prevent pain rather than to stop pain. This is why it seems rational to prescribe it in small doses repeated in the course of the same digestion.

The following combination seems to be the best to prescribe: Sod. bicarb., gr. xij.; magn. pond., gr. iv.; pulv. bellad. fol., gr. 1/6.

Patients with dyspeptic pains connected with motor insufficiency must take two of these powders an hour and half an hour before meals, and even half an hour and an hour after the same meal. Patients whose delayed evacuation is connected with a pyloric spasm, produced or kept up by hypersecretion, take these powders during the whole of their digestion, beginning an hour after the meal and continuing at intervals of an hour and a half until the next meal.

This *modus operandi* is to be preferred to Mathieu's treatment. Mathieu gives a teaspoonful of: sod. bicarb., oz. ss.; magn. pond., dr. j.

Bourget's mixture may also be prescribed. It is a solution of dr. ij. of sod. bicarb., dr. ss. sod. phosph. exsic., and sod. sulph., dr. ss., in 1000 c.c. of water; 150 to 200 c.c. to be taken first thing in the morning as soon as the pain appears.

It may be advisable to bring the solution of sod. bicarb. to about 100° F., since it is well known that fluids, the temperature of which closely approaches body heat, are less irritating for the mucous membranes to which they come in contact.

In spite of all this, and in spite of all the advantages of the alkaline treatment with bicarbonate of soda, it cannot be expected to work wonders even in the most suitable cases. A suitable dietetic treatment must by all means be prescribed at the same time. Even if this mode of treatment has to be prolonged as long as the pains persist, it is useless to reduce the dose as soon as the pains are less severe or less frequent; in other words, this treatment must be started at the same time as the dietetic treatment, but it must in no case be prolonged after the dietetic treatment has been stopped.

La toux émétisante des tuberculeux.

By Dr. H. PAILLARD.

After prolonged and careful investigations on this question, Dr. H. Paillard has come to conclusions which are greatly different from the classical views.

About ætiology, several factors have to be considered: First, the overloading of the stomach; big-

meals bring on Morton's cough, therefore, the patient must be directed to adopt fragmentary feeding; second, the fatigue after the meals; this cough is often met with among labourers, workmen, etc., but is not frequent among well-to-do people who can take a complete rest after the meals; third, the period of the disease; Morton's cough is much more common in the first stages of phthisis; fourth, the localisation of the pulmonary lesions; it is very common in the common phthisis of the apices, but very rare when pleurisy has already prevented the movements of the left side of the diaphragm; fifth, the "status dyspepticus"; this was considered by all the classical writers as an essential factor, but the author thinks it is a mere accessory because it is often absent, and, furthermore, cough is not at all constant in all dyspeptic patients.

There are three varieties of Morton's cough: the most typical is the variety which follows on the onset of phthisis; the cough of the later stages of the disease, less frequent, less regular, and more painful; lastly, the variety which bears no relation to meals, but occurs in the morning, especially in patients with pharyngitis, and is not at all special to consumptive patients. The author insists on the feeling of breathlessness which appears after the meals and before the cough.

The pathogeny of Morton's cough has been very much discussed, and the author discusses it again. He is in favour of the mechanical origin of this cough, and shows how Peter's theory is vague and feeble. According to H. Paillard the vomiting is due, as in whooping cough, to the jolts and jerks of the cough, and in this respect he insists on the importance of the condition of the diaphragm in the causation of Morton's cough. Experimentally, he has noticed that the fixation of the left side of the diaphragm almost prevents vomiting; clinically, he has seen that Morton's cough seldom occurs in patients whose left side of the diaphragm has been fixed by a former pleurisy. Conversely, consumptive patients whose left diaphragm has normal or exaggerated movements when breathing or coughing are very often afflicted by the stiffness of the diaphragm, and the "thoracic aspiration" (Arnozan) is deficient; in the second case, *i.e.*, exaggerated movements, the stomach is directly injured and the "thoracic aspiration" is maximum.

As to treatment, H. Paillard recommends to give after each meal a few whiffs of oxygen; these inhalations may be repeated if necessary; they relieve the dyspnœa which is so common after the meals, and reduce the desire to increase the expansion of the thorax and diaphragm; thus the stomach is given sufficient rest to evacuate its contents at a normal rate. This method, as well as the recommendations which we have seen about ætiology, has given excellent results.

"A Hanging."

"The morning wind began to moan,
But still the night went on;
Through its giant loom the web of gloom
Crept till each thread was spun."

There is a bitter chill in the air as I ride along the dark, deserted roads towards the jail, whose gloomy bulk stands out in grim relief against the paleness in the east that shows the night is nearly spent; a thin white mist lies like a pale shroud over the still sleeping land.

The iron gates swing open with a clang. In the dim lantern light a sombre group stands part revealed, whose whispered conversation dies away into an uneasy expectant hush. Straightway we proceed to the gallows, where the rope dangles ready. It is quickly adjusted to its proper length, for this pitiful drama has been thoroughly rehearsed.

Next, to the convict's cell, outside which the warder guard stands with bayonets fixed. We enter: his coat is removed, his wrists are bound, and for the last time he crosses the threshold of his cell, the cell that has been his home for two long weary months, where, watched night and day, he has hoped against hope, not for justice which he has got, but for the pardon which must be denied him.

The grim little procession wends its way quickly to the gallows, at the foot of which he stands, while the warrant for his execution is read, first in English and then in the vernacular; it is not only the chill breezes of early morn that make him shiver!

He passes up the steps on to the fatal platform, his ankles are tied, the cap put on. Over the jail walls the sky is rosy red with the promise of a new day, a day that Pruchu Tingh, son of Tanda Singh Thakur in the Tansil of Shahpur, will never live to see. It is only when he feels the noose around his neck that he breaks the silence he has maintained so long.

"He did not wring his hands as do
Those witless men who dare
To try to rear the changeling Hope
In the cave of Black Despair."

Even now no appeal for pity, no prayer for mercy, passes his lips, but only the cry "Main Hindu han, Ram, Ram!" (a Hindoo am I, praise be to God!)

The jailor and the warders descend the rickety steps; a moment's pause, the signal is given, and the crash of the falling drop seems simultaneous with a dull thud that makes the gallows quiver. When our end comes may it be as merciful and may we meet it with the same fortitude.

Betal, H. WATTS.
December, 1912.

Correspondence.

To the Editor of Guy's Hospital Gazette.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—Ed., G.H.G.]

Dear Sir,—May we remind the Guy's Hospital London University men, both past and present, that the Annual Dinner will be held at the Criterion Restaurant on May 2nd, at 7.45 p.m.? Notices have been sent to the majority of them, but owing to change of address and other reasons it has been found impossible to communicate with all. Would those who have not received notices kindly inform one of us?

The following members have already announced their intention of being present:—C. L. Adeney, F. F. Burghard, H. W. Collier, A. Mantell Daldy, Frederic Durham, J. Fawcett, W. S. George, G. E. Genge-Andrews, W. S. Handley, T. B. Layton, T. D. Lister, P. Seymour Price, Russell J. Reynolds, E. D. Scott, E. I. Spriggs, F. J. Stewart, John Tanner.—Yours faithfully,

C. E. IREDELL,
W. E. TANNER,
Hon. Secs.

Practical Surgical Hints.

3. Tips in Technique.

Incise the posterior layer of the rectus sheath rather far out, otherwise it retracts, and there is trouble in sewing it up.

Peel the skin off the dressings, and not the dressings off the skin ; it hurts less.

Drain the lower end of the larger incision, in a Frank's gastrostomy ; a small leak often results in slight infection there.

After appendicectomy, always draw down the omentum around the cæcum, if you can ; it lessens the danger of spreading infection, and decreases the subsequent pain.

Never tie stitches more tightly than is necessary to secure accurate co-aptation ; they only strangulate the tissue and cause a weak spot due to aseptic necrosis. This is particularly important in relation to hernia.

If you are not sure whether you have opened the sac of a hernia or not, you have not.

Before moving a stiff knee under gas, make sure that the patella is not fixed, too.

In imperforate anus, do not operate until you have made sure that there is not a fæcal discharge from the urethra or the vagina ; if there is, wait until the child is a little older.

In performing an ordinary radical cure, time is saved if the lower edge of the external oblique aponeurosis is well pulled down as soon as it has been opened up ; this brings Poupart's Ligament clearly into view ; a touch with a dissector shows it up still better, and then it can be caught up in a Spencer Wells forceps, "for future reference."

The neck of the sac should be drawn down until the extra-peritoneal fat comes into view, and the deep epigastric artery has been seen. There is then no doubt that the ligature is on the neck, and not below it.

When doing a radical cure of vaginal hydrocele, rub the visceral layer of the tunica vaginalis with dry aseptic gauze, to promote slight inflammation, and adhesions.

A. H. TODD.

Guy's Hospital Musical Society.

The second concert of the session will be held on the evening of Tuesday, May 6th, at 8 p.m., in the Physiological Theatre.

We are glad to be able to announce the re-appearance of the orchestral section, which in itself will lend an added attraction to an excellent programme.

Part-songs by the chorus will include Stanford's "Songs of the Fleet." Mr. Clive Carey has kindly consented to take the soloist rôle therein.

Mr. Denis Brown will make his first appearance as conductor of the Choral Society, and it is sincerely hoped that his first concert will win that deserving praise of a large audience, which will be proof positive of his energy and keenness under the difficult conditions which have attended his first labours in a department of music entirely new to him.—Hon. Secs.,

H. Q. F. THOMPSON.
T. W. SHELDON.

Papers by Guy's Men.

A. S. Blundell Bankart, M.C., F.R.C.S. : The Technique of Excision of Cervical Ribs.—*Lancet*, 5th April, 1913.

Noel Dean Bardswell, M.D. : Home Treatment of Tuberculosis and Rules for Living.—*Special Practitioner*, January, 1913.

Major R. Tilbury Brown, R.A.M.C. : Sanitary Report on Manœuvres, Burma Division, 1912.—*Journal of R.A.M.C.*, March, 1913.

T. D. Lister, M.D. B.S. : Pulmonary Tuberculosis in Relation to Life Assurance.—*Special Practitioner*, January, 1913.

A. W. Ormond, F.R.C.S. : The Eye in Relation to Tuberculosis.—*Special Practitioner*, January, 1913.

F. J. Steward, M.S., F.R.C.S. : Lecture II. on Calculus in Upper Urinary Tract.—*Clinical Journal*, 2nd April, 1913.

Jejunal and Gastro-jejunal Ulcers.

CLINICAL LECTURE BY R. P. ROWLANDS.

Gentlemen,—Up to the present time about one hundred cases of this rare and grave complication of gastro-jejunostomy have been recorded, and I happen to have seen two. One of my patients was shown last year before the Royal Society of Medicine. The other is now in the hospital. It is significant that the complication has never been recorded after the operation for malignant disease, for if a poor general condition had much to do with the causation, the complication ought to be common in these marasmic patients. The diminution or absence of free hydrochloric acid in their gastric juice is the most probable explanation of this immunity. On the other hand, it is estimated that this complication has followed about 1·5 per cent. of gastro-jejunostomies for *non-malignant disease*. One or more ulcers may develop either at the anastomosis (gastro-jejunal), or in the jejunum usually just below it (jejunal). About one-third are gastro-jejunal and two-thirds jejunal. The efferent limb of the jejunum is the one most commonly affected. This grave complication is very rare (although not unknown) after the modern posterior operation with a large anastomosis made between the lower part of the stomach and the jejunum quite near its origin. In the great majority it has followed anterior gastro-jejunostomy, and, above all, after entero-anastomosis, or the en γ type of operation, in both of which the acid gastric juice, unmixed with the alkaline bile and pancreatic juice comes into contact with the mucous membrane of the jejunum (Figs. 1 and 2). Errors of technique and after-treatment are mainly responsible for it. The uncertain causes of the original ulceration of the stomach or duodenum may still remain. Some of the most likely are chronic septic absorption from an inflamed appendix or gall-bladder, or the ingestion of infective material from a septic mouth. Chronic constipation and errors of habit and diet are almost certainly contributory causes. The acute ulcer of the jejunum, coming and sometimes perforating within about nine days of the operation, is partly septic and partly traumatic in origin. The gastro-jejunal often means incomplete healing at the anastomosis. A small opening with gastric stasis seems to be an important factor, and possibly an unabsorbable suture another. This ulceration is very difficult to cure, and is very apt to lead to perforation at any time from nine days to several years after gastro-jejunostomy. As a rule, this catastrophe is preceded by a normal interval without any digestive symptoms for months or several years. Then there is a period of indigestion with symptoms simulating those of duodenal ulcer, except that the pain, which the patient often describes as burning, is usually situated to the left of the middle line about the level of the umbilicus. Further, its relation to food is far less striking, although it is generally aggravated by solid food, so that the patient limits his diet, loses flesh, and becomes anæmic. Sometimes the pain is relieved by food, but it comes on again in an hour or two. Usually there are nausea and loss of appetite, and occasionally vomiting, and even hæmatemesis, with signs of dilatation of the stomach. There is often tenderness and resistance to the left of the umbilicus, and there may be an induration here due to plastic peritonitis, with adhesion to the parieties, and even a cutaneous fistula may form. At any time signs of perforative peritonitis may develop. In another class of case there is no period of indigestion, but the patient, who appears to be in perfect health, is suddenly seized with violent abdominal pain, and all the signs of spreading peritonitis soon develop.

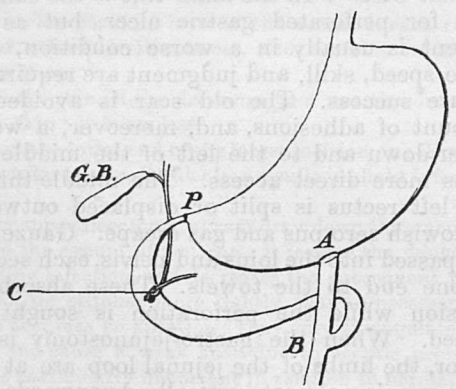
Operation for Perforated Jejunal or Gastro-Jejunal Ulcer —In the main this is the same as that for perforated gastric ulcer, but as the patient is usually in a worse condition, even more speed, skill, and judgment are required to ensure success. The old scar is avoided on account of adhesions, and, moreover, a wound lower down and to the left of the middle line gives more direct access. The middle third of the left rectus is split or displaced outwards. Yellowish sero-pus and gas escape. Gauze rolls are passed into the loins and pelvis, each secured at one end to the towels. These absorb the effusion while the perforation is sought and closed. When the gastro-jejunostomy is anterior, the limbs of the jejunal loop are at once seen running almost vertically downwards from the stomach, and a perforation is seen either at or just below the anastomosis. Sometimes it is near the entero-anastomosis. This is closed with a catgut stitch, reinforced with linen thread. When the gastro-jejunostomy is posterior, and therefore usually of the Y-shaped type, the omentum and transverse colon may be so adherent as to be difficult to bring forwards and upwards out of the way. The adhesions

are separated by gauze dissection, and all bleeding vessels are tied. The condition of the patient rarely allows a radical operation at this stage, but the size of the anastomotic opening, and pylorus should be ascertained, so that some forecast of the future may be made. Sometimes there is time to enlarge the anastomotic opening, after Finney's method of enlarging the pylorus. The peritoneal cavity is cleansed by gauze rolls as already mentioned, but if the extravasation be extensive, lavage may be chosen. The wound is completely closed, but in most cases drainage is established through a stab wound above the pubis. Through this a split rubber tube, containing a wick of gauze, is passed towards the pelvis.

Every attempt is made to heal the ulcer by careful medical treatment. This consists essentially of rest, and bland albuminous and fatty foods, with alkalies to neutralise the over-acid gastric juice. If this fails, a radical operation must be undertaken, if the condition of the patient is good enough.

The following case illustrates some of the difficulties that may be met.

Case I. *Anterior Gastro-jejunostomy; Perforated Jejunal Ulcer; Suture and Drainage. Later detachment of Jejunum; Excision of Ulcer; Gastro-duodenostomy. Recovery.**—E.R., male, aged 30. June, 1905; anterior gastro-jejunostomy, elsewhere, for pyloric obstruction. Complete relief for four and a half years. Then pain



Case I.—Fig. 1.—*C.* Common bile and pancreatic ducts opening into duodenum. Gastric ulcer, en γ method. *A* to *B.* liable to ulcerate. *P* to *C.* site of duodenal ulcer.

in abdomen to left of navel, partly relieved by food. In April, 1910, sudden very severe pain between shoulders, as if a knife had been stuck in. Could not stand up straight. "Got home with great difficulty and was in bed for two days. Since then a heavy sort of pain like a stone on the left side towards navel." Later pain got more severe but was relieved by food for a time. Appetite fair. Bowels very free. Wasted. For three weeks before perforation pain unusually severe.

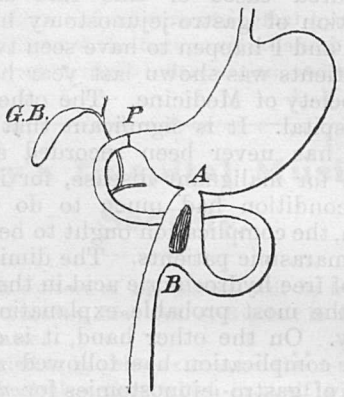


Fig. 2.—Gastro-jejunostomy with entero-anastomosis. *A* to *B.* liable to ulcerate.

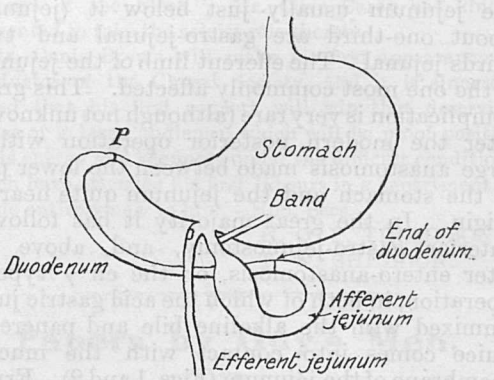


Fig. 3.—Ant. operation. *P.* stenosed pylorus. Contracted stoma, dilated afferent limb of jejunum. Band dragging upon its end. Perforation of afferent jejunum.

On September 2, 1910, at 6.30 p.m., during micturition, suddenly felt a terrible burning and sharp aching pain running downwards from navel to pubes. Pain not relieved by morphia. Patient admitted to Guy's Hospital seven hours after perforation, and abdomen opened half an hour later. Large amount of sero-purulent sanious fluid and gas escaped. The pelvis, both flanks, and the subdiaphragmatic space on both sides were full of this sero-purulent liquid. Anterior gastro-jejunostomy without entero-anastomosis found; proximal

*Some of this account was published in the Trans. Royal Soc. of Medicine, 1912.

limb of jejunum greatly dilated and hypertrophied. Dense adhesion between its gastric end and parieties, indicating old perforation in April. Large perforation in distal limb one inch below gastro-jejunal opening. The latter only three-quarters of an inch in diameter. Perforation closed, abdomen washed out, and tube inserted at lower angle of wound. Patient did well while in hospital, but soon afterwards symptoms returned in spite of continued medical treatment. Readmitted once for prolonged medical treatment. Improved a great deal, but had not been out many days before old pain and vomiting returned. Burning pain and feeling of bursting.

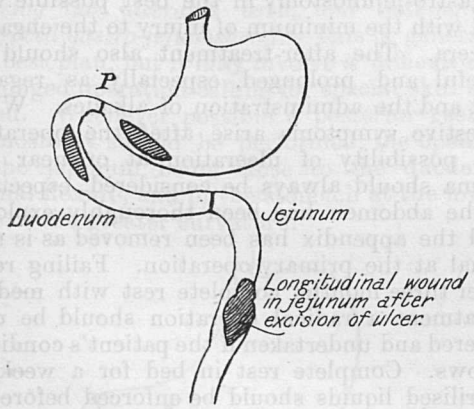


Fig. 4.—Incisions in stomach and duodenum are shown.

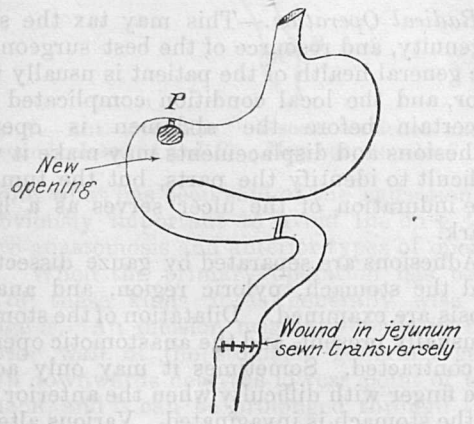
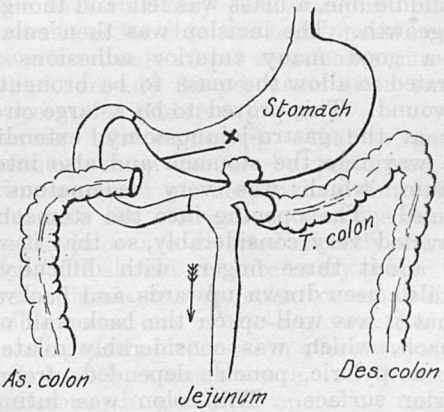


Fig. 5.

Operation, May, 1911: Jejunal ulcer now adherent to the liver, detached, and thus opened. Pylorus almost occluded and adherent high up and far back. Jejunum then detached from stomach. Ulceration around stoma and jejunal ulcer excised. Large jejunal wound closed transversely without narrowing of lumen. Gastric wound enlarged up and to the right for three inches, and joined to similar opening made in front of first and second part of mobilized duodenum. Symptoms have abated. Patient has gained weight and he was seen by me quite well eighteen months later.

Sometimes a gastro-jejunal or jejunal ulcer becomes adherent to or even invades the anterior abdominal wall or one of the solid viscera, especially the liver or pancreas. Occasionally it opens on the skin or into a neighbouring hollow viscus, especially the transverse colon. I have been able to find five recorded instances of this complication. The following is an additional one.

Case 2. *Gastro-jejunal Ulcer opening into Transverse Colon, five years after Posterior Gastro-jejunostomy.*—Male, aged 50. Chronic alcoholic, had posterior gastro-jejunostomy without a loop performed five years ago for obstruction, following duodenal ulcer. He did well, and remained well for over four years, and he left off alcohol for a time. About a year ago he gradually returned to his old habits, and began to have indigestion with pain in the epigastrium, vomiting, and diarrhœa. The vomiting often came on in attacks lasting a few days or weeks. These attacks became more



Case II.—Fig. 6.—Posterior operation, ulceration at anastomosis with opening into transverse colon. New opening made at X which was really lower than the old one.

frequent, and since October the bowels have been moved from 6 to 12 times every day. The vomit was sometimes copious and foul, and the stools large, offensive, pale and liquid. The friends say the patient has been drinking heavily of late. When I saw him on February 5th, vomiting and diarrhœa had been almost con-

tinuous for four days, and he looked very ill, pale, and thin. His pulse was quick and feeble, and his temperature sub-normal. The abdomen was carinated. No tumour could be felt in the abdomen or pelvis. There was no tenderness anywhere except on the left of the epigastrium. The patient was admitted into Guy's and infused. He revived like a faded flower, but he had no appetite, and could only take liquids. The vomiting and diarrhœa almost disappeared, but any attempt to take food brought on the vomiting. Therefore, I decided to explore the abdomen, expecting to find possibly an inflamed appendix or possibly a peptic jejunal ulcer, or a growth of the colon out of reach at the splenic or hepatic flexures.

Operation on February 10th, 1913.—Dr. Page gave gas and oxygen. A very long incision was made immediately to the right of the old wound in the right rectus. A great many adhesions were found between the great omentum, the anterior wall of the stomach, and the parietal peritoneum. The cæcum was found, and the appendix containing several stones was found adherent in the pelvis. It was also constricted for about an inch at its middle, clearly indicating an old severe attack of appendicitis. It was removed in the usual way. The colon was normal, except that the transverse was somewhat dilated. On following it up, and to the left of the middle line, a mass was felt and thought to be a growth. The incision was then enlarged, and a good many anterior adhesions were separated to allow the mass to be brought into the wound. This proved to be a large circular ulcer at the gastro-jejunostomy, extending a little way into the stomach and also into the jejunum, which was very œdematous and inflamed. The opening into the stomach had contracted very considerably, so that it would only admit three fingers with difficulty. It had also been drawn upwards and backwards, so that it was well up on the back wall of the stomach, which was considerably dilated, so that a pyloric pouch depended from the anterior surface. The colon was intimately adherent to the ulcer, and on investigating the anterior wall of the stomach and passing the finger into the anastomosis it could also be passed forwards into the lumen of the colon, there being a large communication between the anastomosis and the colon. The great omentum was quite small and was puckered up to the transverse colon. It was not thought safe to attempt a resection of the ulcerated area involving as it would a resection of a portion of the colon as well as portions of the stomach and jejunum. It was thought better to perform a large anterior gastro-jejunostomy where the parts came easily into contact at the lower and right part of the stomach. This was done, a four-inch opening being made and catgut being used for the deep suture. It was thought that the free drainage thus provided would probably lead to healing of the ulcer. The patient improved a good deal after the operation, and was able to eat without vomiting. Occasionally he has diarrhœa, and is now making very slow progress.

Every endeavour should be made to prevent the formation of gastro-jejunal or jejunal ulceration by great care in performing the operation of gastro-jejunostomy in the best possible way and with the minimum of injury to the engaged viscera. The after-treatment also should be careful and prolonged, especially as regards diet and the administration of alkalies. When digestive symptoms arise after the operation the possibility of ulceration at or near the stoma should always be considered, especially if the abdomen has been thoroughly explored and the appendix has been removed as is now usual at the primary operation. Failing relief after three months' complete rest with medical treatment a radical operation should be considered and undertaken if the patient's condition allows. Complete rest in bed for a week on sterilised liquids should be enforced before the operation, and alkalies in large doses should be administered in the hope of diminishing the acidity of the gastric juice.

Radical Operation.—This may tax the skill, ingenuity, and resource of the best surgeon, for the general health of the patient is usually very poor, and the local condition complicated and uncertain before the abdomen is opened. Adhesions and displacements may make it very difficult to identify the parts, but the tumour-like induration of the ulcer serves as a landmark.

Adhesions are separated by gauze dissection, and the stomach, pyloric region, and anastomosis are examined. Dilatation of the stomach is usually present, and the anastomotic opening is contracted. Sometimes it may only admit one finger with difficulty when the anterior wall of the stomach is invaginated. Various alternative operations may be considered.

(i.) *Enlarging the anastomosis after Finney's method of enlarging the pylorus.* This is the speediest and probably the safest way of providing free drainage of the stomach, and this may promote the healing of the ulcer for it

diminishes the acidity of the gastric juice, relieves pain, and improves the nutrition by allowing the patient to eat more.

In some cases a local but not circumferential ulcer at the stoma may be excised at the same time, and more frequently a jejunal one may be removed.

The operation is not likely to do much good when there is any gross fault at the anastomosis, or when the latter is of the γ type, or entero-anastomosis has been performed, for the acid gastric juice unmixed with the alkaline secretions will still pour over the jejunal mucosa just below the stoma.

(ii.) *Detaching the jejunum from the stomach, excising the ulcerated area, and making an improved gastro-jejunostomy.*—This is generally the best plan, but it may involve a difficult and prolonged operation calling for special skill and speed. Whenever possible a posterior gastro-jejunostomy should be performed, the opening in the jejunum being close to the duodeno-jejunal flexure, and in the stomach at the lower part of the greater curvature.

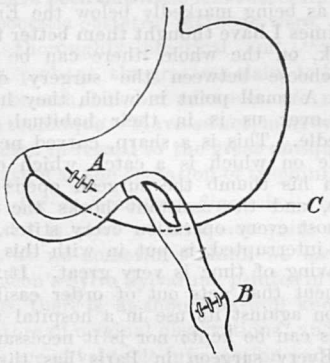


Fig. 7.—Ant. operation. Viscera detached and wounds closed (*A* and *B*). New operation at *C*.

From what has been said of the causation it is obviously important to avoid the en γ, the entero-anastomosis and anterior types of operation. When the primary operation has been one of these kinds it is generally wise to change it. An incision originally made in the anterior wall of the stomach, generally gets drawn downwards near the lowest point of the stomach, and it can be prolonged through the greater curvature into the posterior wall of the stomach, but some care is necessary to avoid the large vessels below the curvature. The opening in the jejunum in these cases is at least six inches from the duodeno-jejunal flexure, and must be closed. This must be done without narrowing the lumen. Another opening is made close to the origin of the jejunum and joined to the enlarged opening in the stomach.

The alternative method of gastro-duodenostomy which I used in Case I has proved very satisfactory, and has the undoubted advantages, especially in these exhausted patients, of (*a*) exposing no part of the jejunum or even of the duodenum to the destructive action of unneutralised gastric juice, and (*b*) avoiding all risk of "vicious circle or regurgitant vomiting."

Adhesions about the duodenum and pylorus may make the operation difficult or impossible. Careful gauze dissection and mobilising the duodenum are of great assistance. As regards the opening in the stomach, it is very easy to enlarge this upwards and to the right, and there is no need to clear the vessels away from the greater curvature.

When an entero-anastomosis exists, the loop of jejunum between it and the stomach must be excised. When the en γ operation exists, the whole or greater part of the piece of jejunum extending from the stomach to the end-to-side anastomosis must be removed, the opening thus left enlarged, and its edges joined to an enlarged gastric opening.

It is curious that in a large proportion of the operations for jejunal ulcer the patient has been left with the en γ type of anastomosis—just the type most to be avoided—and it is possible that this may partly account for the poor results so far obtained from operations for this condition, only 40 per cent. being cured by one operation and 28 per cent. after two or more operations (Paterson).

Paterson has suggested "that a gastro-jejunostomy en γ should be performed, but with implantation of the proximal limb of the jejunum into the stomach, so that the bile and pancreatic juice are diverted directly into the stomach." I should not care to try this.

When a fistula into the colon or small intestine complicates one of these ulcers, the difficulties are greatly increased in every way. The patient's health is much worse, and the extent of interference in a radical operation must be greater.

(a) *Palliative operation.*—Another gastro-jejunostomy for drainage and feeding purposes may allow the ulcer and fistula to heal, but there is little evidence of this at present available.

(b) *Radical operation.*—The jejunum and colon are detached from the stomach and from each other, the ulcerated areas are excised, a new gastro-jejunostomy performed, and the opening in the colon is closed without narrowing its lumen.

When the primary operation is posterior, the mesocolic vessels will probably have to be interfered with, and this may add to the difficulties of the operation.

Conclusions.

1. Jejunal and gastro-jejunal ulceration is due chiefly to errors of technique allowing acid gastric juice to pour over the jejunal mucosa before it is neutralised by the bile and pancreatic juice.

2. Mechanical damage at or near the suture line together with the digestive effect of the gastric juice may prevent healing at the anastomosis. Coarse and unsuitable food may delay healing.

3. The causes of the original ulceration in the stomach or duodenum may still be active.

4. The posterior operation with a large low opening in the stomach, and a similar opening just below the origin of the jejunum, appears to be the least likely to be followed by ulceration at or below the stoma.

5. A jejunal ulcer, owing to the thinness of the wall, is very much more likely to perforate than is a gastric ulcer. For the same reason a gastro-jejunal ulcer, especially when the gastro-enterostomy is posterior and therefore protected, is not so likely to perforate. It may open the transverse colon.

6. The treatment, both medical and surgical, is difficult. Perforation is graver than perforation of gastric or duodenal ulcer. Detachment of the engaged viscera with excision of the ulcerated areas, and the formation of a new simple posterior operation, is probably the best treatment. Entero-anastomosis and the γ-method are to be avoided.

Notes on some of the Hospitals of Paris.

IV.

Bazy, on the morning when I first called on him, asked me to wait a moment as he had to see a patient. An attendant then came in with a little girl aged about fourteen, who was suffering from renal tuberculosis. She sat down in a high surgical chair, and the attendant—who appeared to be a sort of Coles—wheeled up a table carrying dressings and catheters. Some lotion was passed into the bladder, a cystoscope slipped in, and Bazy, after a quick glance down it, ran a catheter up the right ureter, fixed it to the thigh with a bit of strapping, withdrew the cystoscope, and emptied the bladder. The little girl then jumped down and walked back to the ward. It was all done so quickly and quietly, in three minutes she had gone, that I was left rather breathless.

The instruments used at the Beaujou differ only slightly from those in our Genito-Urinary Department. Bazy uses a cystoscope with an arrangement of intercepting wheels on it which propel the ureteric catheters, and the catheters he has in separate flexible steel cases which screw into the end of the cystoscope in such a way that the catheter is introduced straight from its sterilised case.

Besides this I saw him do several hysterectomies and appendicectomies. He removes the appendix in every case of salpingitis, calling it "the flirt," from its habit of conveying and receiving infection. He operated on one very bad retro-cæcal appendix while I was there. It was a very big appendix, and ran right up behind the liver. There had been several previous attacks, and the adhesions were very dense, but Bazy removed the whole appendix by cutting through the serous layer at its base and stripping out the whole thing retro-peritoneally.

Another surgeon at the Beaujou was one morning announced to do a gastro-enterostomy. It is a rare operation at that hospital and nearly every student in the place turned up to see it. I must confess that I was very disappointed; the operator did not use clamps of any sort, and the bleeding was very profuse; in a short time he had about ten pairs of Spencer-Wells on different parts of the stomach wall, and proceeded to do laborious stitching on bleeding and damaged tissues.

But this was really the only operation I saw which struck me as being markedly below the English standard. At times I have thought them better than we are, but I think, on the whole, there can be remarkably little to choose between the surgery of the two countries. A small point in which they have a great advantage over us is in their habitual use of the slotted needle. This is a sharp, curved needle with a firm handle on which is a catch which controls the eye. With his thumb the surgeon opens the eye of the needle, and the assistant hooks the suture into it. In almost every operation every stitch, either continuous or interrupted, is put in with this instrument, and the saving of time is very great. It is obviously an instrument that gets out of order easily, but that is no reason against its use in a hospital where many instruments can be kept; nor is it necessarily a coarse needle. Every surgeon in Paris has three different sizes beside him for his different sutures.

A recent article in the Gazette mentioned the inferiority of the United States nursing when compared with ours. I hope the French nursing is the worst in the world, if not, there is some terrible work going on somewhere. It would be amusing to show a Guy's Sister over a Paris hospital. The nursing staff remind one somewhat of the better class "Gamp" of Hickman's Folly. Particularly I recall "Blanche," the Sister at Babinski's Out-Patients. Everyone there is always shouting for Blanche, who comes shambling forward, wiping her hands on a dirty apron, and vaguely searches for whatever is wanted. I remember watching her filling some big test-tubes with ice one morning: as the chunks of ice were too big she bit them up in her mouth and then spat them into the tube—and she was rather a bad shot, too!

Occasionally one sees very good nurses; they are ladies belonging to the International Red Cross Society. I believe they have a very hard time, as they none of them live at the hospitals, and have to begin their work before seven in the morning. They are

given a great deal of responsibility, and appear to be under no control by the Sisters, but they work together in all amiability. At one clinique it was the custom of the surgeon to kiss the hands of the Croix Rouge nurses on entering the theatre—a picturesque ceremony which might well be extended to this side of the Channel! T. I. B.

Notes from an Old Edition of Francis Bacon's Sylva Sylvarum.

Research into the writings and works of illustrious ancients is certainly one of the best methods of rendering apparent the truth of the old adage relating to the lack of subsolar novelty. A superficial study of Hippocrates is, for instance, sufficient to convince one of the amazing modernity of his views and discoveries, or rather to shock one with the realization of the snail-like characteristics of medical advancement. The medicine of the Hippocratic period differs by very little from the medicine of to-day. Ætiology in those days was an even more extensive study than it is at present; in Pathology there has been definite advance. Diagnosis has become rather more accurate and differential; while Treatment can surely have been but little less successful then than now. Hippocratic obstetric methods were, with a few exceptions, thoroughly practical and "up-to-date." Surgery has, perhaps, the greatest claim to honour as a progressive branch, but her advances are mainly concerned with technique. Have we not, moreover, recently been instructed in regard to the great antiquity of such skilled operating as the operation of trephining?

So much for a prefatory digression, whereof the principal moral is, that we have not quite so much to boast about as we sometimes think we have. In the edition of Bacon's Sylva Sylvarum, printed in 1651, which lies before us, there is, as should be well known, a truly wonderful store of original observations; and the book is at once a source of valuable information and of innocent amusement. The author's experimental thoroughness and clarity of vision mingle, curiously in our eyes, with strangely fantastical methods of explaining the observed phenomena.

He calls his work "A Natural History," and, indeed, there are few things noteworthy under such a head upon which he fails to touch. The physics of sound production and transmission, the growth of plants and animals, mineralogy, horticuiture, the indestructibility of matter, and various problems of life, disease, and death, all receive treatment turn and turn about, and throughout the volume the extraordinary keenness of Bacon's intellect is made manifest by his continual recognition of the extreme value of actual experiment.

Readers of this journal will doubtless be most interested in those passages which have a bearing upon matters medical. Of such passages we have endeavoured to skim the cream, but they are obviously better read in the context. One of the first which we encounter relates to an original but expensive method of providing a hot pack in cases of renal disease—"Heraclitus for the cure of the Dropsie was put into the Warm Belly of an Oxe newly slain." The passage occurs in a disquisition on the therapeutic uses of blood, in the course of which Bacon sagely reminds us that ". . . the device of Ficinus, Touching the Sucking of Bloud out of the Arme of a wholesome young Man; for the Restauration of Strength in Old Men, is very frivolous." We do not know if Sir Cooper Perry finds himself in agreement with those who "use the bloud of Kittins warme, to cure the Disease called Saint Anthonie's Fire; and to restore the Flesh and Skin."

An unusual suggestion as to the origin of the scourge of syphilis, nauseating and fortunately quite improbable, is contained in the ensuing paragraph. "The French (which put off the name of the French Disease into the name of the Disease of Naples) doe report that at the Siege of Naples, there were certain wicked Merchants that Barrelled up Man's flesh (of some that had been lately slain in Barbary), and sold it for Tumey; and that upon that foule and high Nourishment, was the Originall of that Disease. Which may well be; for it is certain that the Caniballs in the West Indies eat Man's flesh; and the West Indies were full of the Pocks when they were first discovered." There are several notes on the value of Massage, a very ancient process, as an aid to the maintenance of health. . . . "And therefore gentle Frication draweth forth the Nourishment, by making the Parts a little hungry, and heating them; whereby they call forth Nourishment better. The Frication I wish to be done in the Morning. It is also best done by the Hand or a piece of Scarlet-wooll, wet a little with Oyle of Almonds mingled with a small Quantity of Bay-salt, or Saffron." And again, "Frications make the Parts more Fleshie and Full . . . the cause is for that they draw greater Quantity of Spirits and Blood to the Parts."

There is also a very wise discourse on the beneficial effects of exercise, and further on the detrimental effects of over-exercise. ". . . But generally Exercise, if it be much, is no Friend to the Prolongation of Life; Which is one cause, why Women live longer than Men, because they strive lesse."

In his "Experiment touching cure by Custome," Bacon says, "Therefore a wise Physitian will consider whether a Disease be Incurable; or whether the Just Cure of it be not full of perill; And if he find it to be such let him resort to a Palliation; and alleviate the Symptome, without busying himself too much with the perfect cure: And many times (if the Patient be indeed patient) that Course will exceed all Expectation."

A lengthy discussion is devoted to the question of purgation—the physician's first concern throughout the ages—and many are the suggestions put forward in regard to the actions of the various groups of purges; of these not all are to be found in modern text-books of pharmacology, but all are worth considering, if only for their ingenuity, and the quaintness of their terminology.

"The Causes of Purging are divers . . . The first is That whatsoever cannot be overcome and digested by the Stomack, is by the Stomack either put up by vomit, or put downe to the Guts." Lack of space, unfortunately, forbids the inclusion of the long list of substances quoted.

"A Second Cause is Mordication of the Orifices of the Parts; especially of the Mesentery Veins; as it is seen that Salt or any such thing that is sharp and biting, put into the Fundament, doth provoke that part to expell."

"The Third Cause is Attraction, for I doe not deny but that purging Medicines have in them a direct Force of Attraction; as Drawing Plaster has in Surgery."

"The Fourth Cause is Flatuositie: For winde stirred moveth to expell: And we finde that (in effect) all Purgers, have in them a raw Spirit or Winde."

"The Fifth Cause is Compression or Crushing . . . . So we see that taking Cold moveth loosenesse by Contraction of the skin and outward Parts."

"The Sixth Cause is Lubrefaction and Relaxation." Paraffin finds no mention among the drugs coming under this category.

"The Seventh Cause is Abstersion; which is plainly a Scouring off, or Incision of the more viscious Humors.'

The recognition of the method of checking hæmorrhage by bringing the part into contact with a fluid containing the substances essential for the promotion of clotting is shown in the "Experiment Touching the Stanching of Blood." "So it hath been tryed, that the part that bleedeth, being thrust into the Body of a Capon, Sheep, new ript and bleeding, hath Stanched Blood."

We have purposely kept till the last the ensuing striking passages, which, from the fact that they are concerned with processes supposed to be essentially modern, particularly inspired our preamble. The first brings to light the antiquity of Skin-grafting as a plastic and reparative process.

"There hath gone a report, almost undoubted; and that under severall Names; of certain men that had great Noses, who, being weary of the derision of people, have cut off the Bunches of Hillocks of their Noses; and then making a wide gash in their Armes, having held their Noses in place for a certaine time; And so brought forth fair and comely Noses; Which if it be true, it shewes plainly, the Consent of Flesh unto Flesh, especially in Live Fleshes."

Our final quotation is one of great interest, and should prove especially pleasing to Mr. Lane and his adherents, in so far as it demonstrates the recognition, by great minds of the past, of the evil effects of the assumption of the erect attitude, and the beneficial results which accrue from the use of abdominal support.

"Lying, not Erect, but Hollow, which is the Making of the Bed; or with the Legs gathered up, which is in the Posture of the Body, is the more wholesome. The Reason is, the better comforting of the Stomach, which is by that less Pensile: And we see, that in Weake Stomachs, the Laying of the Legs high, and the Knees almost to the mouth, helpeth, and comforteth. We see also that Galley-slaves, notwithstanding their Miserie otherwise, are commonly Fat and Fleshie. And the Reason is, because the Stomach is supported somewhat in Sitting; and is Pensile in Standing or Going. And therefore for Prolongation of Life, it is good to choose those Exercises, where the Limbs move more than the Stomach, and Belly; as in Rowing, and in Sawing, being Set."

The Nursing of Acute Nephritis.

So many cases of acute nephritis become chronic and the unfortunate patients more or less condemned to an invalid life, that one wonders if, by a little *more* careful nursing, a larger number might not be able to join the ranks of those cured. Perhaps those nurses who have had only little experience of medical work may appreciate these few hints on various prominent details.

A large proportion of cases occur during or after an attack of scarlet fever, and unfortunately many appear to be the result of chill during the desquamating stage. Some of these surely might be prevented by a little more extreme care; it should be the object of every nurse to see to it that a patient's chance of permanent recovery is not hindered in the very slightest degree by irresponsible indolence or want of thought.

A great deal more responsibility rests upon the nurse than she sometimes realises, perhaps with regard to apparently trivial and unimportant instructions, for which she does not grasp the reason.

Nothing is so trivial as to be unimportant in the nursing of any case; success depends upon the exhaustive and accurate application of certain principles.

In nephritis there is inflammation of one or both kidneys, possibly and probably with a varying amount of hæmorrhage.

Rest—absolute rest is indicated for the body as a whole and for the kidneys themselves. This is also necessary on account of the risk to the heart. The patient is kept absolutely in bed, not doing anything for himself that requires any exertion; pillows must be so arranged that the body is supported and the muscles are relaxed.

Diet is regulated with the idea of giving the kidneys as little work to do as possible, and, as one of their functions is to extract urea from the blood, it follows that to obtain this rest nitrogenous food must be withheld. Milk is the chief food to depend upon; some think it insufficient, and may supplement it with sugars and true farinaceous foods and even fats.

Considerable patience and determination to help are required on the patient's side, and all a nurses' tact and ingenuity are called forth to render a necessarily, somewhat monotonous diet as varied as possible. Milk may be taken hot or cold (flavoured with tea, coffee, almond, vanilla), or as junket and jelly. It may be diluted with soda or barley water, the former being undesirable if there be much flatulence. Fruit and vegetables are often

allowed, sometimes also cream, sugars, treacle, jam. Exceptionally, eggs may be allowed, and this helps considerably in giving more change.

An excellent way of giving milk is to flavour it with shredded onion (Spanish) or celery seed, strain, and serve very hot with pepper and salt (if allowed).

Extra fluids should be given—milk counting rather as food, in the form of plain water, tea, coffee, lemon or orangeade, imperial drink. This assists in the flushing out of the kidneys, but discretion must be used as it is quite possible, given a very willing patient not caring to rebel, to cause œdema if the output of fluid does not correspond to the intake.

Extreme accuracy and care are required in the collection, measurement, and testing of the urine. Diminution in quantity, or changes in constituents, making the nurse alert to notice changes in the condition of her patient.

Severe headache, nausea, drowsiness, and rigors, with scanty, albuminous urine, deficient in urea, may be indications of uræmia (caused by the presence in the blood, of urea and other poisons). If not checked at once, this condition becomes very serious and may lead to coma, convulsions, or even death.

Treatment is usually prompt and energetic. If little urine is being passed, the action of the kidneys must, if possible, be supplemented by that of the skin. Warmth is an essential of the treatment during the whole illness; the patient must be clothed in flannel, a broad flannel binder is useful, and every effort must be made to avoid chill and to keep the skin in good condition. Blankets only, should be used for the bed, and all utensils warmed before use. The surface of the body should not be exposed for even the shortest length of time.

The greatest care must be taken to avoid injury by burning, pressure, or bruising, as the skin is particularly liable to inflammation, or at best to heal very slowly, thus causing increased pain and discomfort. Very painful and obstinate wounds may be caused by the pressure or heat of an insufficiently covered hot bottle, the bruising of a back by a bedpan or against the lower end of the bed when stretching. These patients should not be allowed to sit out of bed when it is being made.

A good wash with hot water, from head to foot, night and morning, will help to keep the skin in good condition, care, of course, being taken that it is done between blankets and that no part is exposed. It is wise to have a hot blanket and shirt always ready; prompt application will often check a rigor, make a patient sweat and so ward off hours of misery and discomfort.

Sweating may be promoted by means of hot-air baths, which must be well and conscientiously given. Often a patient does not respond—possibly because the heat is allowed to leak out from a carelessly tucked-up bed, or maybe the windows near are left open, or insufficient fluid is given to drink. In hospital, we use the electric hot-air baths—a cradle to which several large electric lights are attached, the necessary current being obtained from a special wall plug. This is easier and much safer to apply than the old-fashioned spirit lamp, with long chimney to convey the heat into the bed, though one is dependent upon the latter if electric current is not available.

To give an electric hot air bath in bed, roll in a long warm mackintosh and hot blanket, remove the shirt and roll the patient up in the blanket, see that it is well tucked round the neck and feet. Then put on the cradle, taking care that the lights and frame do not touch any part of the patient, cover with an asbestos sheet, put thermometer in position inside and turn the light on. A considerate nurse will think to cover the cradle before connecting up, as the great sudden light is very unpleasant and may actually do considerable harm and cause headache. Cover the patient and cradle with two more blankets, then another big mackintosh and a rug over all, tuck well in all round the bed and round the neck. The head should be low, and some patients like a cold wet compress on the head, but it is unnecessary if sweating is profuse. The thermometer can be watched if placed swinging from the cradle in such a position that it can be seen by untucking the blankets at the side for a moment. Unless ordered otherwise, the heat should rise to 140° Fahr., the lights turned off and the patient left for half an hour; sometimes it is allowed to reach 170°. Plenty of warm drinks, barley water and lemon, Imperial drink, tea, and lemonade should be given.

Remove the cradle, roll the patient in a fresh hot blanket and take away the damp blankets and mackintosh, rub down thoroughly with hot towels and clothe in fresh hot garments. It is better to use powder as sparingly as possible for these patients. It is of no use to leave a patient to feed himself, this necessitates his hands at any rate being free, neither is it safe to leave any patient alone; he must be carefully watched, there is always risk of sudden colapse. Some patients, of course, can stand much greater heat than others without distress.

If the old method is used, the patient is prepared in the same way, but extra care must be taken that the feet are well protected, as the current of hot air enters by the foot of the bed. Two cradles or one long one are necessary, and precautions must be taken against fire. There is always the danger of a sudden gust of air taking the flame up through the chimney actually into the bed, so that the whole bed and apparatus must be effectually protected from draughts. In other respects the management of the bath is the same as in the other method.

If there be no response to this treatment, it may be wise to try an ordinary hot bath, allowing the patient to remain in it for about fifteen minutes, and then put him back to bed packed up with plenty of hot blankets and bottles. This is a very good plan with children who are sometimes frightened and restless.

It is very risky to persist in the application of dry heat if the skin does not respond, it may cause pyrexia.

Very satisfactory results may sometimes be obtained from a hot pack. Hot blanket and mackintosh should

be rolled in, the patient stripped and rolled entirely into a sheet, or, if possible, a blanket wrung out of very hot water, quickly covered with two more blankets and mackintosh and rug, and pack round with hot water bottles.

Drinks must be given and patient watched in the same way as for the baths. He should be left in for twenty minutes to half an hour, then left between hot blankets and rubbed down when sweating has ceased.

If these means all fail, an injection of pilocarpine 1—4 minims may be ordered. Sometimes this is given in conjunction with hot air bath, but unless so ordered, the patient is rolled into a hot blanket with mackintosh under him; give the injection hypodermically and cover with hot blankets; give hot drinks and put hot bottles round him. When sweating has ceased, blankets should be removed gradually, and the patient rubbed down as described before. Pilocarpine is a powerful heart depressant, and is, therefore, very cautiously used.

Free action of the bowels is necessary (accurate records are essential); a saline purge is usually given every morning before food. Mercury is rarely given, these patients being particularly susceptible to its action. Jalap is often given, especially if œdema is present. It causes watery stools, and so helps to remove some of the superfluous fluid. Sometimes colitis is present and severe diarrhœa, for which colon wash-outs may be ordered.

Nausea and retching are often persistent and very distressing. Tinct. iodi. in water may stop it, or a mustard leaf applied to the epigastrium. Care must be taken in the application of counter-irritants, and blistering must be avoided. The mouth and tongue need attention; very often patients would take milk and milky fluids with more readiness if water were given before and after, and if the mouth were frequently rinsed out.

Headache is difficult to relieve; drugs such as caffein or phenacetin may be ordered. Some patients like lint wrung out in spirit lotion; if this be used, it should be kept wet and cold, though great discomfort may be caused by a dripping application which soaks the pillow.

For the lumbar pain, often a dull, persistent aching, hot fomentations, poultices, or rubber bottle may be applied.

Sometimes dry cupping is ordered and, much more rarely, wet cupping. Two special glasses are used, one for each side; they should be vaselined round the edge and well up the sides. The skin across the loins should be rubbed over with vaseline to further diminish the risk of burning. A small square of blotting or filter paper should be soaked in methylated spirit and stuck to the top of the glass with a little vaseline. Light the paper, and as soon as the glass is just warm apply firmly and evenly whilst the paper is alight. No force or pressure is required if the glass is put quite against the skin so that no air can enter round the edges; the light goes out immediately, a vacuum is formed, and the glass kept in position by suction. Care should be taken that the spirit does not form streams down the sides of the glass and that the burning paper does not drop on to the skin. The glasses should be put in the right place, over the kidneys, and they can be easily removed by pressing down the skin just under the rim sufficiently to allow air to enter. Never try to twist or pull them off. No dressing is required.

In wet cupping the skin is incised, and the cups applied as above. The wounds should bleed freely, and hot fomentations are applied afterwards.

A very common feature of the disease is œdema, varying from a slightly noticeable puffiness to a condition in which the limbs become greatly enlarged and the skin tense and shiny. The skin must be made to act as freely as possible, fluids are not limited, but *salt* is usually prohibited. The patient should be frequently weighed, daily if possible.

Fluid may be removed from the tissues by means of Southey's tubes, small silver cannulæ with lateral holes, or by acupuncture, punctures made in the skin of the legs by triangular cutting needles. The latter method is very effectual; rigid aseptic precautions must be taken and aseptic dressings applied. The heels must be watched as they are inclined to become sodden and sore. The great danger in this method of treatment is sepsis. The bed may be blocked up from the head to assist gravitation of the fluid, and so relieve pressure in the chest.

The illness is more often than not a long and wearisome one, and nurses will often find patients moody and irritable. They must remember that this is one characteristic of the disease, and a good nurse will not judge her patient harshly, but will do everything in her power to avoid any cause for depression or discomfort. Mental worry and excitement have a marked effect on the physical condition, and every effort must be made to keep him in an optimistic and contented frame of mind.

This calls for much patience, tact, and unselfishness, and applies practically to all nursing. The mental attitude of a patient towards his general condition is a very large factor to be considered, and one that is sometimes overlooked—unfortunately.

A good nurse will always try to give and to do a little more than is necessary rather than just enough or just too little.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the Gazette *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

Appointments.

Medical School Appointments.

April—June, 1913.

Clinical Assistants.—Messrs. J. A. Ryle, W. R. Reynell, O. G. Morgan, A. B. Danby, G. E. Genge-Andrews, J. L. Perceval.

Clinical Assistants in Medical Wards.—Messrs. G. Covell, E. D. Scott (Dr. Hale White); W. C. Whitworth, A. Tilbury (Dr. Pitt); E. S. Taylor, W. L. Gwyn-Davies (Sir Cooper Perry); F. W. Lawson, H. Sharpe (Dr. Shaw).

Clinical Assistants in Surgical Wards.—A. C. Clifford (Mr. Dunn); J. W. Kemp (Sir Alfred Fripp); F. D. Annesley (Mr. Steward).

Dressers in Special Departments:—

Throat and Ear, Children, Genito-Urinary.—Messrs. T. R. Trounce, W. D. Galloway, H. W. Evans, D. R. Jones.

Throat and Ear, Skin, Orthopædic.—Messrs. F. E. R. Laborda, D. W. Jones, C. R. Smith.

Eye, Nervous System.—Messrs. H. Gould, F. Gilbert L. Scott, W. H. Ogilvie (Mr. Eason); J. R. Barrow-Clough, H. G. Dresing, N. H. W. Saw, R. C. Matson (Mr. Ormond).

Obstetric Dressers and Externs.—Messrs. C. G. McClymont, L. Muir Smith, A. H. Taymour, S. Wilson, D. C. Scott, F. C. S. Broome, W. E. Tanner, H. P. Whitworth, A. Wills, A. N. Minns, C. F. Pedley, T. W. Sheldon, P. R. Boswell, C. Dean, E. C. W. Starling, A. Abd-el-Al, E. R. Bailey, R. B. Campion.

Extern only.—Mr. R. P. Ninnis.

Surgeons' Dressers.—Messrs. P. D. Scott, W. M. Lansdale, O. G. Parry-Jones (Mr. Lane); H. Stephenson, S. S. B. Harrison, R. Sells (Mr. Dunn); H. Parry-Price, W. H. Nicholls, C. de W. Gibb (Sir Alfred Fripp); G. L. Attwater, B. Burnside, R. W. Cushing (Mr. Steward).

Medical Ward Clerks (Extension).—Messrs. A. S. Liebson, L. Horsley, L. R. Pickett (Dr. Hale White); A. H. Harkness, W. A. Young, F. L. Spalding (Dr. Pitt); J. S. Cocks, C. E. Petley, J. E. Davies (Sir Cooper Perry); D. O. Richards, A. L. Anthony, J. H. Parry (Dr. Shaw). R. H. Holmes, W. L. Partridge, K. L. Bates, W. A. Easton, N. E. Kendall, A. F. Rook, C. C. G. Gibson, E. J. Cooke, S. W. Coffin, A. C. M. Coxon, M. Chadwick, L. R. Broster, R. Curle, E. W. Bowell, C. P. Symonds, G. D. Gripper.

Post-mortem Clerks.—Messrs. R. O. H. Jones, F. H. Dodd, C. S. L. Roberts, J. York Moore, F. V. Bevan Brown.

Assistant Surgeons' Dressers.—Messrs. R. W. P. Jackson, C. H. Medlock, J. F. Mackenzie (Mr. Fagge); K. Westman, B. Sampson (Mr. Rowlands); H. Q. F. Thompson, L. S. Fry (Mr. Turner); W. L. E. Reynolds, A. K. Day Lewis (Mr. Hughes); R. Quesada, H. F. T. Hogben (Mr. Davies-Colley).

Surgical Ward Clerks.—Messrs. J. E. Clark, J. G. Stevens.

Pathological Assistants to Surgical Registrars.—Messrs. H. W. Evans, E. S. Taylor, C. F. Pedley.

Student Assistants in Bacteriological Department.—Messrs. W. E. Tanner, A. Wills, C. Dean.

Student Demonstrators of Microscopical Pathology.—Messrs. H. W. Evans, W. L. Gwyn-Davies.

Student Demonstrator of Anatomy.—Mr. A. D. Marston.

Pathological Assistants to the Demonstrators in Morbid Anatomy.—Messrs. C. S. L. Roberts, J. York Moore.

Naval and Military.

Staff-Surgeon H. R. H. Denny, R.N., has been appointed to *Amphion* (undated).

Captain A. W. Gater, R.A.M.C., has taken up duty at Winchester.

Lieut.-Colonel C. H. L. Meyer, I.M.S., has been permitted to retire, with effect from March 15th, 1913.

Lieutenant F. J. Kolaporewalla, I.M.S., has been promoted Captain, with effect form 24th October, 1912.

Civil.

E. L. Elliott, M.B., B.S. Lond., M.R.C.S., L.R.C.P., to be District Medical Officer and Public Vaccinator, No. 7 District, Sevenoaks Union.

George Evans, M.B. Lond., has been appointed Senior Assistant Medical Officer to New Essex and Colchester Asylum, Severalls—to be opened shortly.

H. Corry Mann, M.D., M.R.C.P., has been appointed Consultant Medical Officer to Foundation St. Olave's and St. Saviour's Grammar Schools.

Wilberforce Smith, M.B., B.S., F.R.C.S., has been appointed Gynæcologist to the South Marylebone Dispensary, and Surgeon-Accoucheur to the Western General Dispensary.

Pass List.

University of London.

Second Examinamion for Medical Degrees, March, 1913.

Part I.—Organic and Applied Chemistry.

Alcock, J. A. M.	Gray, H. M.
Bensted, H. J.	Heath, T. L.
de Robillard, E.	Mayer, R. G.
Glover, E. N.	Waghorn, L. P.

Woodruff, K. M. C.

Part II.—Anatomy, Physiology, Pharmacology.

Clark, J. E.	Jones, R. O. H.
Jones, J. G.	Knott, F. A.

Thompson, H. Q. F.

University of Durham.

First Examination for Degrees, M.B., B.S.

Elementary, Anatomy, and Biology.

R. S. Millar.

Chemistry and Physics.

C. T. Helsham. M. C. Joynt. H. S. Sterne-Howitt.

Third Examination.

Jap-ah-Chit, M.R.C.S., L.R.C.P. D. C. Scott.

M.D. for Practitioners of 15 Years Standing.

Coleman, J. G. B., M.R.C.S., L.R.C.P.
Thomas, E. Rae, M.R.C.S., L.R.C.P.
M.B., B.S.
Dodd, H. G.

Society of Apothecaries.

Surgery.

A. C. Dickson (Sections I and II).

Forensic Medicine.

C. E. Reckitt.

R.A.M. Corps.

Examinations for Promotion.

For Lieut.-Colonel—In Appendix XI., K.R., Sub-head D (III).
Major H. D. Packer.
For Major—In Appendix XI., K.R., D. II and III.
Captains G. H. Rees and D. P. Watson.
For Captain—In Appendix XI., K.R., D II and III.
Lieutenant D. Reynolds.

Reviews, etc.

Human Embryology and Morphology. By Arthur Keith, LL.D., F.R.C.S. Third edition. (Edward Arnold, London.) Price 15s. net.

Since the previous edition of this work, much progress has been made in our knowledge of development, and, as Professor Keith points out, "It is now possible to take up the story from the beginning and trace the rise of the human embryo from the ovum, the fœtus from the embryo. . ."

The arrangement of the different sections has been entirely altered, affording a consecutive picture of the many changes which untimately result in a physiological entity.

Nowadays every student of medicine must possess a working acquaintance with the essentials of embryology, not only in order to pass examinations, but also as a valuable aid in correlating many difficulties in the study of anatomy and physiology.

The language is simple and the facts so disposed as to be easily assimilable, whilst many new diagrams have been added to the exclusion of some of the older figures.

Keith's is so well known to Guy's men that we need do little more than reassure them as to its continued excellence, and state that, in our opinion, it stands unrivalled as a compact, interesting account of the elements of human embryology.

Forensic Medicine and Toxicology. By C. O. Hawthorne, M.D. Third edition. (Edward Arnold, London.) Price 6s. net.

Students do not generally find time to gain more than a hurried smattering of Medical Jurisprudence, and should, therefore, hail with delight the appearance of this small handbook on the subject.

The author would do well to arrange the subject-matter in a more systematic manner and to eliminate unnecessary padding—the "bête noire" of enjoyable study.

We can recommend this book as being helpful in mastering the principles of the subject, and as giving a very good general notion of medico-legal knowledge.

The subject of intestinal stasis is of peculiar interest to Guy's men, associated as it is both in England and America with the name of Mr. Lane; and Dr. Jordan's paper in *The Practitioner,* of which we are glad to receive a reprint, illustrates the question from the point of view of the radiographer. He considers appendicular stasis, the ileal kink, and the simple ileal stasis. Any marked degree of stasis in the colon will eventually tend to a delay in the passage of the contents of the bowel into the cæcum, so the ileal coils sag down into the pelvis, with the result that the terminal coil of the ileum rises almost vertically to its function with the large intestine; and this vertical path necessarily causes a still further slowing of the normal passage.

In two cases Dr. Jordan found some bismuth in the pelvic coils of the ileum after 80 hours, the ileal coils lying limp and "dead" in the pelvis.

In less severe cases the continual pull exerted by the overloaded ileum at its mesentery results in the formation of thickened bands, so that the cæcum hangs down suspended on one side of a band and the ileum on the other, and at the point of suspension the lumen of the ileum is greatly narrowed. It is explained with great clearness how this sluggishness of movement of the contents of the gut leads to various alimentary disturbances.

The duodenum is most sensitive, and Dr. Jordan convincingly shows how prolonged ileal stasis leads inevitably to distension, congestion, ulceration, and finally cicatrisation and stenosis of that part of the bowel. These several points he illustrates by a truly admirable series of X-ray photographs.

Births.

BOLUS.—On March 25th, at St. Aubyn Street, Devonport, the wife of P. R. Bolus, of a daughter.

DISMORR.—On March 25th, at Milton House, Gravesend, the wife of C. J. S. Dismorr, M.R.C.S., L.R.C.P. of a son.

DYMOTT.—On April 3rd, at New Road, Green Street Green, the wife of Vivian Dymott, of a son.

Deaths.

GALABIN.—On March 25th, at Tapley, Bishopsteignton, from pneumonia after five days' illness, Alfred Lewis Galabin, M.A., M.D. Cantab., F.R.C.P., aged 70.

MUIR.—On March 6th, at his residence, London, Surgeon-General H. Skey Muir, M.D., F.Z.S., C.B., A.M.S., in his 72nd year.

Ed.—F. G. L. S.

GUY'S HOSPITAL GAZETTE.

VOL. XXVII., No. 648.] APRIL 26, 1913. [SIXPENCE.

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Passim.

ON Tuesday, June 3rd, the Right Hon. Arthur J. Balfour, M.P., a Governor of the Hospital, has consented formally to open the New Buildings, comprising the new Laboratories of Chemistry and Physics, the new Pathological Department, and the new School of Dentistry.

After luncheon in the Court Room, Mr. Balfour will pass to the Physiological Theatre, where the Ceremony will commence about 2.20 p.m. The Gallery of the Theatre will be reserved for Students, and places will be balloted for on May 27th. Applications for places in the Gallery should be addressed to the Secretary of the Students' Club before 9 a.m. on Monday, May 26th. No Student may receive more than one seat.

Later in the afternoon a Garden Party will be held, when the new School Buildings will be open for inspection. A limited number of invitations will be issued from the Medical School Office. Past and Present Students desiring to bring guests, either ladies or gentlemen, should make application for tickets on or before May 26th to the Dean of the Medical School, Guy's Hospital. Owing to lack of space it is regretted that these invitations cannot admit holders to the Ceremony in the Physiological Theatre.

"LECTURES once were useful," says Dr. Johnson; "but now when all can read and books are so numerous, lectures are unnecessary. If your attention fail, and you miss a part of the lecture, the lecture is lost; you cannot go back as you do upon a book."

Dr. Johnson is never so dogmatic as upon a question to which there are many answers. And at the risk of offending such as read the humble views of an editor—and we are afraid they are not numerically very formidable—we would advance some defence of lectures in general, as in a recent issue we made an appeal for the Clinical Lectures. First, then, for the disadvantages—and they are too much discussed to need more than mentioning. The trouble of attending them takes foremost rank, we are afraid; next, perhaps, the obligation to attend. We will certainly allow that it seems rather unreasonable that the regulations should compel a fixed number of lectures to be attended; the knowledge has to be acquired—that is seen to by the examiners; surely the method of acquisition might be left to the student—at any rate in matters where a purely practical know-

ledge is not required. With regard to Dr. Johnson's objection "if you miss a part, the lecture is lost," here again is a serious disadvantage. Very few men completely grasp any piece of knowledge at the first acquaintance. It is only after a mental disintegration and re-elaboration that the fact is woven into the texture of memory. And supposing that the lecturer, to meet this difficulty, reiterates his points sufficiently often to impress all his discourse on his auditors, there is some probability that half what he says will be common knowledge to the senior man, who will on that account find part of the time wasted. And in the matter of note-taking, without which we maintain the permanent value of lectures is but slight, there are some slow writers to whom the taking of notes is difficult, and with the most rapid lecturers impossible.

So much, then, for disadvantages. Our readers, if they dislike lectures, will have each his own objection which will be more powerful to him than any we can adduce. Among the advantages surely stands the variety which the lecture gives: tired of reading and tired of seeing cases we have here a third method of gaining knowledge. For the mind is approached by another avenue—that of auditory impression; and to the reading man who relies so much upon the visual impression such a change can hardly be otherwise than beneficial. Again, in the lecturer we generally meet the surgeon or physician at his best, or at any rate at his clearest; he is able to give his views and his facts in a systematical form, set out in relation to each other. In the wards, talk he never so wisely, he is almost bound to digress and he will be interrupted by those who wish to display their knowledge or hide the opposite. In the lecture room—as in the Lost and Found column—no questions are asked. The presence of an audience is a stimulus to him, for the lecturer would not be human if the appreciation of his hearers, spontaneously expressed, were not an object worth attaining. Lately we asked a certain physician of this hospital whose treatment of a certain subject in a recent lecture had caused somewhat unusual interest, for his permission to publish his lecture in this Journal. His notes were not full, he told us, but he assured us that if one student had carried away some useful piece of knowledge he would gladly go to the trouble of preparing the manuscript; needless to say, this was not meant to be a reflection on the carrying power of the student, but the expression of a fear that lectures in general are very little appreciated.

Yet there is a sort of man to whom the lecture theatre is a place of more or less vile durance. He is not necessarily a fool, he may be industrious and even brilliant. But it is our firm opinion—given, we hope, with due deference—that this class could be converted to a very different creed if men made the best and fullest use of note-taking. "You are my means of forgetting," says Dr. Shaw to his ward-clerks; who shall deny the note-book, particularly the lecture note-book, the same beneficent office?

Some time ago we appealed to old Guy's men to send intruction and direction to the younger men embarking on private practice. Alas! our hint has not been very fully acted upon. But America has supplied the need in a book directed not particularly to us, but to the world of young medical men in general. The work is good and needed, but we must confess to reading with some amusement the following worldly advice. "When you are examining an applicant for admission to a secret lodge or fraternal insurance company, after routine examination look into the nose for spurs, polypi, or enlarged turbinates. . . . As lodge physicians are expected to give free medical attendance only, any surgical work that is required will be paid for at regular rates, and when you consider that almost every man has some trouble with his nose, you will see the size of the field. The problem before you is simply to convince him that the operation is necessary and beneficial, and knowing this is true, that should be a simple matter." We hate the phrase, but surely this is making them "pay through the nose!"

We congratulate Mr. M. F. Hopson on the signal honour conferred on him in his appointment on the Board of Examiners in Dental Surgery.

We learn with interest that there seems some definite prospect of the Crystal Palace being properly repaired and devoted to some good purpose. What this purpose is we have no certain information, but rumours have it that educational use is to be made of it. Here, again, we are in doubt as to how it can serve any useful end. If children are to be taught in it they will be hardly better off than in their more or less comfortable schools—indeed it seems to us one of the most uncomfortable places it has been our lot to see. Is it to be the home and centre of some University extension scheme? We fail to see any particular advantages it can offer. Others say it is to be devoted to scientific purposes with all the vagueness that the term implies; others declare for medical interests. In this last connection it can hardly be considered suitable for any form of hospital or invalid home (as we remember lately a newspaper seriously suggested) but for research work it might be as good, or as bad, as any normally constructed laboratory would be. In these days so many good purposes require a building and cannot afford it, that it is rather melancholy to see a building which yearns for a good purpose and goes a-begging.

A communication will shortly be sent to every old Guy's man, drawing attention to the projected revision and amplification of the Clubs' Union Year Book. The Union desires to increase the utility of its annual publication, more particularly by the provision of fuller facts concerning the past and present activities of Guy's men. The Directory of the Year Book of life members is to be amplified by adding to the present bare statement of name and address, particulars relating to period of studentship' appointments, and distinctions, and such other details as may render the location and identification of former colleagues a more easy task. An attempt will also be made to provide in a special section of the work a fuller record of all notices of appointments, births, marriages, and deaths. Secretaries of clubs and societies will be encouraged to contribute, in addition to the usual details concerning membership of committees and the list of rules, reports of the doings of their several institutions.

By these and similar means it is hoped to transform the Year Book into an interesting volume of reference, and to provide a valuable addition for the consulting-room table. Old Guy's men are asked to assist in the completion of the work by filling up a form which shortly will be sent them; they are requested to intimate their desire to receive any of the three publications—the Gazette, the Reports, or the Clubs' Union Directory.

On another page will be found the Audited Statement of Guy's Hospital Ball (1912). The total receipts appear to have been £204 1s. 0d., and the expenses £161 5s. 3d., leaving a profit balance of £42 15s. 9d. This sum has been disposed of by a grant of £20 to Guy's Hospital Ladies' Association, and a grant of £15 to Guy's Hospital Maternity Samaritan Fund, the remaining balance of £7 15s. 9d. being held over as a reserve for the next Ball.

It will be noticed that the profit of the Ball is not so large as last year. The causes of this are several—the item of £18 18s. for Joyce's Band, the cost of a special die for programmes and correspondence, and the reserve fund, which is to be held over. The task of arranging so large a function is no sinecure and needs a large share of public spirit for its undertaking, and we offer our warmest thanks to all who concerned themselves in the success of a most enjoyable evening.

We have to congratulate Mr. A. Neville Cox, a late Editor of the Gazette, on his appointment as Tuberculosis Officer to the County Borough of Brighton, and wish him every success.

F. G. L. S.

University of London.

At a Meeting of the Senate held on 9th March the following was recognised a Teacher of the University in the subject indicated:—

Dr. Thomas Martin Lowry—Chemistry.

Royal Naval Medical Service.

EXAMINATION FOR COMMISSIONS.

A. M. Henry, M.R.C.S., L.R.C.P., L.D.S. 1st place of fourteen candidates with 1,785 marks (maximum obtainable, 2,400).

University of London Officers Training Corps.

MEDICAL UNIT.

It is intended to hold a Whitsuntide Camp for the Unit at Shenley, in the vicinity of London, from Friday evening, May 9th, to Tuesday, May 13th. Details are published below. The cost to Cadets will be 10s. for the whole period, inclusive of travelling expenses. Cadets wishing to be present must send their names to Captain A. M. H. Gray, at University College Hospital, by Friday, May 2nd, together with 10s. to cover cost.

Time Table at Whitsuntide Camp.

Reveille ...	5.30 a.m.	Tea	4.30 p.m.
1st Parade	6.15–7 a.m.	Lecture ...	5.15–6 p.m.
Sick Parade ...	6.30 a.m.	Duties Mount ...	6.30 p.m.
Breakfast	7.30 a.m.	Dinner	7 p.m.
Line Inspection	8.30 a.m.	Retreat	7.30 p.m.
Orderly Room...	8.40 a.m.	1st Post	9.30 p.m.
2nd Parade ...	9 a.m.	Last Post... ...	10 p.m.
Lunch	1 p.m.	Lights Out	...10.15 p.m.
3rd Parade ...	2 p.m.		

SCHEME OF DRILLS, Etc.

Friday Evening.—Lecture on Camp Sanitation.

	Saturday.	Monday.	Tuesday.	Sunday.	
1st Parade	Squad Drill.	Squad and Company Drill.	Squad and Company Drill.	9.30 a.m.	Church Parade.
2nd Parade				11 a.m.–12 noon	
9–10.30	Company Drill.	Stretcher Drill.	Squad and Company Drill.	Seniors	Appreciation of Scheme of Staff Ride.
10.45–11.15	War Organization.	Organization of the Dressing Station.	Evacuation of the Wounded.	Juniors	Instruction in Equipment.
11.15–12.30				12.15–1 p.m.	Organisation of the Field Ambulance.
Seniors	Tent Pitching and Map Reading.	Dressing Station Duties.	Return to London.	2 p.m.	
Juniors	Stretcher Drill.	Company Drill.		Seniors	Staff Ride.
				Juniors	Selection of Sites for Regimental Aid Posts.
3rd Parade					
2–3.30				8 p.m.	Lecture— Hygiene of the March.
Seniors	Will act as Instructors.	Field Exercises, The Dressing Station.			
Juniors	Tent Pitching and Map Reading.				
3.30–4	Regimental Medical Establishments				
5.15–6	Lecture: How a Man goes Sick.				
8 p.m.	Use of Compass in the Search for the Wounded.				

N.B.—1. Cadets should all bring pencils and note books.
2. Cadets will be able to return on Monday night if unable to stay for Tuesday morning.
3. On Friday the train will leave St. Pancras at 5.25 p.m. for Radlett.

Camp Standing Orders and other details will be published shortly.

H. H. TOOTH, Major,
O.C. Medical Unit.

"B" SECTION—COMPANY NOTICES.

1. Drills will begin again in the week starting 5th May. Notices as to times will be posted shortly.

2. Cadets are reminded that they are ineligible to attend camp unless the requisite number of drills have first been put in.

3. They are urgently urged to attend the Whitsuntide camp if they possibly can. Two drills per diem will be counted during the camp. Cadets at Guy's may give their names and subscriptions to Cadet-Sergeant F. D. Annesley instead of sending them direct to Captain Gray.

4. Recruits of 1912—13 are warned that they will not be accepted for re-engagement in 1914—15 unless they have taken Certificate A.

T. B. LAYTON, Lieut.
O.C. "B" Section.

Medical Education in Germany.

By E. P. POULTON.

The subject of medical education in Germany has been so much discussed in England lately that this article might be considered superfluous. It has been written with the idea that those who have had no time to read the long account of English and German medical schools in the Flexner report may still be interested to read about some experiences gathered during a year's stay in Germany. The radical differences between the English and German systems are largely due to the differences in their development. In Germany, from the earliest times, medical education has been carried out by the Universities, and the teaching has naturally followed the same lines as the teaching in other subjects, where lectures have always played the most important part. This is the origin of the clinical lecture, which is invested with a peculiar dignity in the mind of every German, and it would be difficult for a German student to realise the possibility of medical teaching without any formal lectures at all.

In England, it is true, the medical faculties have long existed in the two ancient Universities of Oxford and Cambridge, but in these places actual medical teaching has been at a disadvantage from the lack of clinical material; and so by far the greater part of medical education was originally carried out in large towns by the method of apprenticeship, and this means that students learnt from actual experience and not from lectures. It was natural that when the various authorities began to co-ordinate our education and organise it on definite lines, the system adopted should have been an extension of the old apprenticeships, rather than the introduction from the Continent of what would have been an entirely new method of teaching.

In Germany the clinical lecture is given by the Professor himself every day in the week. One or more cases are selected from the wards, and usually the whole bed is wheeled into the clinic. The history of the case is first read out, and this has usually been written in very great detail by the Professor's assistant, or under the direct supervision of the latter. The case is then thoroughly examined by the professor, and the diagnosis, treatment, and prognosis are discussed, with the aid of diagrams, skiagraphic plates, the projection of lantern slides, and of histological preparations, etc. Behind the lecturer there is a switchboard, by means of which the electrical reactions may be demonstrated in nervous cases.

A general account of the disease may be accompanied by a full description of any special investigations that may have been carried out in the laboratory. In a case of diabetes, for example, a table was given showing the exact intake of food during several weeks, with daily analyses of the urine, showing the amount of the total nitrogen, ammonia, sugar, and acetone excreted. This led on to a general explanation of the treatment, with an account of the so-called oatmeal cure. In a case of gout, the uric acid in the urine had also been determined daily. The diminution in its excretion was shown preceding an acute attack. Later on, a dose of atophan was administered, and a marked increase in the uric acid excretion was shown. The patient, on being asked, stated that since taking the atophan he had had no further attack, and needless to say, in his own mind he ascribed his improvement entirely to the powder.

A great point is made of performing the usual laboratory tests for urine, etc., in the lecture room. The more complicated bacteriological processes are described, and cultivations may be handed round in various infective cases. By such means as these a very complete picture of a disease is presented within the hour's lecture, and when one takes into consideration the fact that one of the most important qualifications of a professor is his power to lecture, it may readily be imagined that the whole effect is extremely impressive and the attention of the audience is not likely to wander. It has required the practice of generations to bring the clinical lecture in Germany to its present state of perfection.

In Munich there are two medical clinics, and a year ago the second medical clinic was by far the most popular, being attended by 350 students, both men and women. The lecture room was really much too small, every available foot of space being taken up by the spectators, in the gangways, as well as on chairs and benches. It was necessary to arrive at least ten minutes before the lecture began to get a place at all. High up along the sides of the room were two galleries from which two serried ranks of men could get a distant view of the proceedings. When the case was brought in, a dozen men at the entrance always had to stand up, holding their chairs above their heads to allow the bed to pass.

The custom in Germany has always been to associate the clinical lecture with a certain amount of practical work performed by the students themselves. In Munich before each lecture began four students were called down as "Praktikanten." They stood in a row behind the patient's bed, ready to perform tests, observe physical signs, and answer questions. Owing to the large number of students in the class it was rarely the case that a man was called down more than twice during a session. In spite of this custom the actual practical instruction given during the lecture was very small. On many days the Praktikanten received no attention at all. The kind of question asked and the answers showed that the men were only just beginning their clinical work.

To the unbiassed observer the association of any kind of practical work with a clinical lecture to some hundreds of students is obviously very unsuitable, because, if the professor personally superintended a full examination of the patient by three or four beginners, he would be wasting the time of the rest of the class. As a result, the Praktikanten are usually left pretty much alone, and it seems possible the practice may be continued at Munich for the same sort of reason that men attend some lectures in England, not because they feel they will get much benefit from them, but because they have to be signed up.

The clinical lecture forms the foundation of the teaching. As has been pointed out, it is almost completely non-practical in nature. However, there are various ways in which actual practical instruction is given. To begin with, there are various compulsory courses, both in the wards and in the laboratory. The most important of these is the percussion course, which includes physical signs and diagnosis generally. It is of an hour's duration twice a week. Last year in Munich the number of students was too large to be taken altogether, so they were divided up and taken in two classes on different days. Even with this arrangement the classes were very unwieldy, four students being assigned to each patient, and two or three wards being used at the same time. The course was taken by the Professor himself; but this is very unusual: in the other universities this work is entirely left to the professor's assistants. The class starts with an informal lecture of a few minutes on the subject in hand, the relation of the organs being demonstrated by means of an anatomical model. The men are then made to demonstrate to the professor the points he has mentioned, by percussion of the patient. A man who has attended all the classes of the course will have had some most valuable instruction, and the various points will have been presented to him more clearly and in more detail than is sometimes the case with us. For instance, when the lungs are percussed the men are made to draw with a blue pencil the position of the base of the lung at the end of a normal expiration and a normal inspiration, and to show the increase at the end of a forced inspiration. At the same time it seems a pity that the men should rarely have any more opportunity of applying their instruction than they can get during the class itself.

Other courses, consisting partly of demonstrations and partly of practical work, are given, *e.g.*, a course on blood, and a course on various laboratory methods, etc.

The first part of a man's clinical work is taken up in prescribed courses of study, and if he attended every lecture he is supposed to, there would be no time left for practical clinical work in the wards as we know it. The curriculum is not divided up into three-monthly periods of medicine, surgery, and obstetrics in rotation with one another, as in England. During term time a man often attends surgical, medical, and obstetric clinics every day in the week, as well as other special courses and lectures. He may also be attending clinics in mental diseases, ophthalmology, diseases of children, etc.

There are still the vacations, which amount to about four months in the year, and many clinical teachers make a special point of urging the men to employ some of this time in work in the wards. As to how far the men avail themselves of the opportunity of working in their local hospitals it is difficult to say for certain. I was told by one man that he thought that 70—80 per cent. of all students did employ some of their vacation in this way. On the other hand, on inquiry in Heidelberg I was told that they never had any students in the wards. The amount of practical work probably varies with the views of the particular professor. A man who has travelled in America or England will probably impress on the students the importance of practical work, and in this case a large percentage of them will probably follow his advice.

Quite apart from the vacations, every man does a certain amount of practical work in the polyclinic, or out-patient department. Here the students thoroughly examine the patients under the direct supervision of the doctor in charge. This work is usually taken towards the end of a man's training, but the exact time is not fixed in any way.

However, there are facilities in certain clinics for practical work of a more thorough nature. In Munich a certain number of men are taken on for definite work in the wards. These men are known as "coassistenten," and their duties are to follow the assistant physician on his daily rounds through the wards, to do the routine laboratory work, to write some of the reports under his supervision, and do any special piece of work he wishes them to do. These posts resemble our clinical clerkships, but there is not very keen competition for them because the coassistenten are expected to spend at least six hours in the hospital each day, and this does not allow them very much time to attend the other clinics and lectures.

Finally, the "Praktisches Jahr" (practical year) has come as a recent institution in Germany. Every man on passing his qualifying examination has to devote one year to hospital work before being allowed to go out into the country and practice. He is called a "Medizinal Praktikant." By this means a man who realises the importance of gaining practical experience will probable manage to remedy the deficiencies of his previous training. But often, this does not happen at all. The posts for Praktikanten in the bigger hospitals where there is considerable competition are not paid. But many small hospitals for special cases, *e.g.*, orthopædics, and even con-

valescent homes, advertise for Praktikanten to come and act as resident medical officers, and they offer a small salary as an inducement, as well as board and lodging. It is obvious that a man who spends his year in doing small appointments of this kind will not gain much practical experience in general medicine.

In comparing the systems of teaching in England and Germany it is really a question as to whether an essentially practical training is better than a theoretical training with a certain amount of practical work thrown in. It is not entirely from prejudice that an Englishman prefers his own system, as may be seen from the fact that its most important features have been adopted by the best American schools. Even in Germany the advantages of more practical work are realised, because the majority of men are going to become practical doctors. At the same time one definite criticism that has been levelled at our system is that the freedom in the wards is too great to be certain of the men learning the elements of physical diagnosis correctly. The answer to this would seem to be that the best course on physical signs in the world is not as valuable as plenty of opportunity for practice; while the fact that the ward teaching in England *is informal does not mean that it is not* thorough.

As a contrast to the formal lectures and courses in Germany, the ward teaching in England is informal, whether given by physicians, registrars, or H.P.'s. The men are given a certain amount of responsibility from the beginning both as regards dressing and writing reports, and in consequence they are under supervision, and in this way they are compelled to do a fair amount of work. In Germany the instruction is carried on in the clinic, which is really outside the hospital. The hospital routine continues as usual when all the students have gone away on their holidays. During the medical training the men have no responsibility towards patients, and it does not matter to anyone except themselves if they do any work or not. Their teachers often do not know their names. The theory of German university education is complete freedom for the students, and this is the case in medicine as well as in the other faculties. If one may say so, the theory is too much of an ideal to be a success. It may have answered in the Middle Ages when the people who studied at universities did it for the sheer love of learning for its own sake, but now things are very different, and the majority of men are benefited by a certain amount of supervision.

It is a significant thing that though there are opportunities in Germany for a practical training like that in England, men do not very often take advantage of them. The chief reason is that when there are two alternatives most men prefer the easier; it is much less effort to be spoonfed by lectures than to work things out in the wards. However, in the smaller universities the association of student with teacher is much closer than was the case at Munich, and more practical work is done. In Munich there were actually 600 students undergoing their clinical training at the same time. It would be difficult to accommodate this number of men in a hospital containing only 400 medical beds.

Apart from the lack of practical work, the question arises as to the educational value of clinical lectures themselves. Their value cannot be exaggerated for a man who has spent a year or two at medicine already. The lecturer is usually a man of considerable personality, and he is always a man of original ideas. His style is clear, and he is constantly throwing new lights on what one has been accustomed to regard as well-worn subjects; he is constantly suggesting possible lines of investigation. However, for a beginner the case is different. The lecture is too advanced, especially for a man with no practical experience, and the succession of original ideas is probably rather bewildering than otherwise.

The qualifying examinations in Germany differ in many ways from those in England. To begin with, there is only one examination which everybody has to pass, and the professor conducts the examination himself. The advantage claimed is that he is able to find out how far his teaching has been successful; but there are some obvious disadvantages. There are no written papers; the examination is chiefly *viva voce*. The professor has four candidates sitting in front of him, all dressed in immaculate frock coats; he asks them questions in turn, noting down the questions and the answers at the same time. These notes are sent to Berlin and kept for future reference, in case a dispute arises as to the fairness of the examiner.

The examination is quite as searching as any written examination in England, but, as in all *viva voces*, the questions are very unequal in difficulty, depending largely on the personal equation of the examiner. I have heard questions on the diseases of the ductless glands lead to a request for the chemical constitution of adrenalin, which was given quite correctly. The candidate also attends at the hospital, and has a long case and short cases as in England. However, at the end of the long case he has to go home and write up the case with the help of books, and present the manuscript next day when he comes up for another *viva*.

The lack of practical experience is allowed for in the examination. For instance, a candidate told me that in a heart case the examiner would not be particular about the correctness of a bruit, because the man would learn to distinguish them later during his practical year.

A substantial part of the professor's income comes from the examination fees of the candidates. If a candidate has failed to pass on two occasions the head of the medical faculty has to be present when

he goes in the third time to see that he is treated fairly. Practically no one fails at the third attempt. This must mean that the examiner lowers the standard of the examination, unconsciously perhaps, for a man who has failed twice already.

It is interesting to note how the different type of examination in Germany has produced a completely different attitude of mind in the German. The remark is often heard that the great disadvantage of the English system of written papers is that a nervous man may absolutely fail in the paper on account of sheer nervousness, whereas a *viva voce* examination gives him a much better chance of conquering his nervousness and doing himself justice. Such an argument seems paradoxical in England. Time after time a man may do a respectably good paper, but nervousness may render him completely aphasic in the *viva* with disastrous results.

Metropolitan Asylums Board.

INSTRUCTION IN FEVERS, May Class, 1913.

A Course of Instruction in the Diagnosis and Treatment of Fevers will be held at each of the undermentioned Hospitals on the days and at the times stated below.

N.B.—Attendance may be commenced during the second month of a course.

North-Eastern Hospital, St. Ann's Road, Tottenham, N. F. H. Thomson, M.B., Medical Superintendent. Monday and Thursday Morning at 11, beginning 1st May. (The stations nearest to the Hospital are St. Ann's Road and West Green.)

North-Western Hospital, Lawn Road, Hampstead, N.W. J. MacCombie, M.D., Medical Superintendent. Tuesday and Friday at 2 p.m., beginning 6th May.

Western Hospital, Seagrave Road, Fulham, S.W. R. M. Bruce, M.R.C.S., Medical Superintendent. Tuesday and Friday at 2 p.m., beginning 6th May.

South-Western Hospital, Landor Road, Stockwell, S.W. F. Foord Caiger, M.D., Medical Superintendent. Tuesday and Friday at 2 p.m., beginning 6th May.

Grove Hospital, Tooting Grove, Tooting Graveney, S.W. J. E. Beggs, M.D., Medical Superintendent. Wednesday at 2.30 p.m., and Saturday Morning at 11, beginning 3rd May.

Brook Hospital, Shooter's Hill, Woolwich. J. B. Byles, M.B., Medical Superintendent. Monday and Thursday at 2.15 p.m., beginning 1st May. (Trams from Woolwich Arsenal or from Well Hall Station (South Eastern Railway) pass close to the Hospital.)

The succeeding course will commence in October, 1913.

In Memoriam—"Bunch."

Obiit. 13, iv., 13.

Famed for his bark, but never known to bite,
A dweller 'twixt the Colonnade and Borough,
Whose coat, it seems, was primarily white,
But whose concealment of that fact was thorough.
He lived beloved of humans, though it's stated
Cats deemed his reputation overrated.

Yclept by all familiarly "Bunch,"
But blessed with a more dignified cognomen;
(For, mark you, how that he was wont to lunch
At titled tables, and his small abdomen
Doubtlessly oft felt comfortably pendant
After a supper with the Superintendent),

Briefly, in fact, "the Superintendent's hound"
One called him—if one wished to curry favour—
But now, alas, a small tear-sprinkled mound
Marks the position of his poor cadaver,
And Bunch begs cakes with Cerberus in Hades
Of less substantial knights and phantom ladies.

Now, though he mingled with the mightiest,
And sought subsistence in exalted quarters,
He was no snob, but frequently addressed
Himself to nurses, students, patients, porters,
In tones distinct, if apt to be incessant,
Yet, retrospectively, extremely pleasant.

Men prized him highly for his sporting trait,
For he was much addicted to the rat-hunt
In caverns under Clinical, where day
Is turned to night, and now and then a cat-hunt
Rendered proceedings vigorous and various
And for my theme a trifle more precarious.

But Time o'ertook him at the last; grey hairs,
Combining with a terminal arthritis,
Made him lose interest in world-affairs,
And those who know how sad the cripple's plight is
Making experiment with lethal doses,
Induced in him the ultimate narcosis.

Bunch is no more! His gay dog-days are done;
And though they find no notice in the daily
Papers of his death, yet everyone
Will join us in our "Ave atque Vale!"
Our hearts are full, and whosoe'er percusses
May gauge how great the difference to us is.

Change of Address.

H. G. Biddle, M.R.C.S., L.R.C.P., from 6, Chandos Place, Broadstairs, to The Cottage, Stradbroke, Eye, Suffolk, after 1st May.

H. J. Spon, M.R.C.S., L.R.C.P. Corrected telephone number, Mayfair 2712.

E. I. Spriggs, M.D., F.R.C.P., from 48, Bryanston Street, Portman Square, W., to Duff House, Banff, N.B.

Four Cases of Heart Block.

Within the last few months there have been four cases at Guy's exemplifying the different varieties of heart block. By the term "heart block" is meant a condition in which there is impairment of the conducting mechanism between the auricle and ventricle. In the normal human heart the chambers which first contract are the auricles, and their contraction is followed by that of the ventricles. The interval between these two contractions varies from 0·12 to 0·17 of a second, and any lengthening of this interval must be considered pathological. This interval can be measured in man either by taking venous and arterial pulse tracings or by the electro-cardiograph.

If venous pulse tracings are taken from the internal jugular vein it is seen that there are three waves occurring during each cardiac cycle. The first is synchronous with the contraction of the auricles, the second with that of the ventricles. The third is due to the rise of intra-auricular pressure which occurs during the time that the auriculo-ventricular valves are closed. The first is known as the auricular or A wave, the second as the carotid or C wave, and the third as the ventricular or V wave. The diagnosis of heart block rests on the recognition of these waves, and of their relations to each other, particularly of the relation of the auricular and carotid waves.

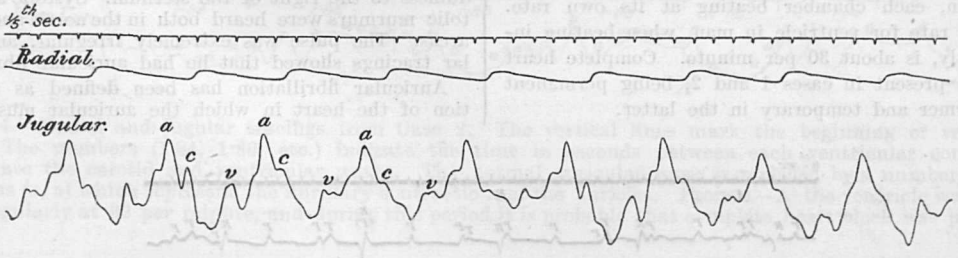

Fig. 1.—Normal radial and jugular tracings. A is the auricular wave, C is the carotid wave, and V is the ventricular wave.

By means of the electro-cardiograph records are obtained of the electrical changes which result from the heart's activity. The first curves representing the changes in the human heart were obtained by Waller using the capillary electrometer. Ten years ago Einthoven introduced the string galvanometer, and this is the instrument which has been found to give the most satisfactory results.

The string galvanometer consists of a powerful electro-magnet between the poles of which is suspended a silvered quartz thread to form a conducting fibre. Any current passed through this fibre causes it to deflect and take up a new position. The image of this fibre is projected on to moving, sensitised paper, and in this way a photographic record of its deflections is obtained.

The two ends of the fibre are connected to the patient examined by wires and suitable electrodes attached either to the two arms or to the right arm and left leg or left arm and left leg. These are the three leads selected by Einthoven, and it has been shown that with this arrangement of the circuit the deflections of the string accurately represent the electrical changes in the heart, due allowance being made for the resistance of the patient and the various parts of the apparatus.

Of the three leads commonly employed, the most serviceable is that from the right arm and left leg. The curve so recorded shows, as a rule, five peaks; the first is associated with the contraction of the two auricles, the last four with that of the two ventricles. These peaks are designated by the letters P, Q, R, S, and T; P being the auricular peak, and Q, R, S, and T the ventricular peaks. While R and T are nearly always obvious in electro-cardiograms, Q and S vary in amplitude, and may be completely absent. It is unnecessary for the present purpose to discuss the explanation of these peaks, but it is important to recognise their relation to the various events of the cardiac cycle.

The conducting mechanism of the heart consists of a strand of neuro-muscular tissue known as the auriculo-ventricular bundle, and it is generally believed that any departure from the normal time relations of auricular and ventricular contractions indicates some impairment of the function of this tissue. The time taken in the passing of the stimulus from auricle to ventricle is estimated graphically by measuring the distance between the beginning of the auricular contraction and the beginning of the ventricular, that is to say, the distance between the A and C waves in the jugular pulse, and the P and R waves in the electro-cardiogram. The intervals so measured are known as the A—C or P—R intervals respectively.

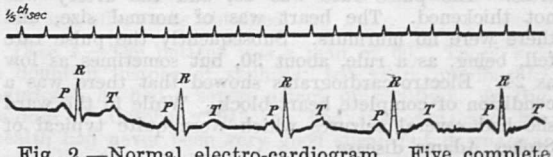

Fig. 2.—Normal electro-cardiogram. Five complete cardiac cycles are shown. P is the auricular wave, R and T are the first and second ventricular waves.

Impaired conduction may manifest itself in various ways; in the slighter forms there is merely a delay in the passage of the stimulus from auricle to ventricle, and this delay is indicated by prolongation of the A—C or P—R intervals. In the more severe forms some impulses from the auricle may fail to reach the ventricle. This is the condition known as "partial heart block." Jugular tracings taken in such a case show that some A waves are followed by C waves, while others are not, and similarly on the electro-cardiogram some P waves are succeeded by R and T waves, while other P waves produce no sign of ventricular contraction.

Partial heart block may be of various grades: sometimes only an occasional ventricular beat is missed, sometimes only every second, third, or fourth auricular contraction evokes a ventricular response, in which case the condition is designated as two-to-one, three-to-one, or four-to-one heart block.

Case 3 affords an example of occasional dropped beats.

Case 4, an example of eight-to-one heart block.

Finally, there is a condition in which the disease of the bundle is so extreme that no impulses from the auricle can pass along it. In these cases the ventricle beats independently of the auricle, taking on a rhythm of its own; in other words, there is complete dissociation between auricular and ventricular contraction, each chamber beating at its own rate. The usual rate for ventricle in man, when beating independently, is about 30 per minute. Complete heart block was present in cases 1 and 2, being permanent in the former and temporary in the latter.

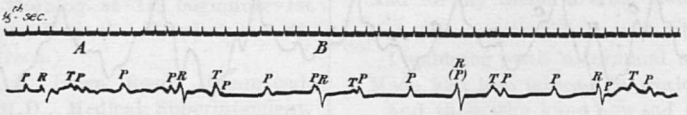

Fig. 3.—Electro-cardiogram from Case 1. Five ventricular contractions (R and T) are shown. The auricular (P) waves occur at regular intervals but bear no fixed relation to the ventricular waves; some precede the ventricular waves, others follow them, and others coincide with them and modify their shape, *e.g.*, at A where P falls upon T, and at B where P falls upon R. The auricular rate is 73, the ventricular 26.

Case 1.—The patient was a married woman of 40 years of age. She had one child at the age of 18. There was no history of rheumatism or syphilis. For some years she had been subject to fainting attacks and dyspnœa on slight exertion. On the day before admission she fainted three times. On admission she looked fairly healthy, and was in no respiratory distress. The pulse rate was 40, and the artery was not thickened. The heart was of normal size, and there were no murmurs. Subsequently the pulse rate fell, being, as a rule, about 30, but sometimes as low as 24. Electro-cardiograms showed that there was a condition of complete heart block. While in the ward she had several seizures which were quite typical of Stokes Adams disease.

The attacks started quite suddenly, there were some convulsive movements of the hands, the breathing became stertorous, the face cyanosed, and the extremities cold and clammy; the attacks lasted a few minutes, and during this time the patient was quite unconscious, and the pulse rate became even slower. Rather a curious feature was the fact that while the patient was regaining consciousness the pulse rate rose—on one occasion to 120—and then slowly regained its usual rate. Unfortunately, the condition of the patient during this period was too serious to permit of electro-cardiographic examination, and so it was not possible to investigate the manner in which the heart was acting, but presumably the ventricle must have been beating in response to auricular contraction. The patient was treated with strychnine and pituitary extract, but neither drug affected the degree of heart block; moderate doses of atropine produced toxic symptoms without raising the pulse rate. The seizures became more frequent, and during the later attacks the patient cried out continuously, so much so, indeed, that she had to be removed to a private room, where she died during an attack four weeks after admission.

Dr. Butterfield has kindly undertaken the histological examination of the auriculo-ventricular bundle, and I hope to add an account of the post-mortem appearances when his investigations are completed.

Case 2.—The patient was a man of 32. He gave a history of rheumatism and syphilis, and had been in hospital on several occasions for attacks of cardiac failure. He was admitted in November, 1912, with dyspnœa and œdema. The apex beat was in the fifth space in the nipple line, and the deep cardiac dulness started one inch external to this; there was no dulness to the right of the sternum. Systolic and diastolic murmurs were heard both in the aortic and mitral areas. The pulse was extremely irregular, and jugular tracings showed that he had auricular fibrillation.

Auricular fibrillation has been defined as a condition of the heart in which the auricular musculature is in constant and in effectual activity, and in which the normal impulses conveyed from the upper to the lower chamber are replaced by rapid and haphazard impulses (1). The co-ordination between the various fibres of the auricle is lost, and the normal contraction of the whole chamber is replaced by rapidly occurring contractions of small groups of fibres. The action of the ventricle is profoundly affected, and the pulse is characterised by marked irregularity; this irregularity is completely disorderly in nature, and all trace of any dominant rhythm is lost.

The patient was treated with digitalis, and improved considerably, but the pulse became very slow, the rate sometimes falling as low as 40. Jugular tracings taken at this time showed that there were short periods during which the ventricle beat regularly at the rate of 32.

It has already been pointed out that when the ventricle beats independently of the auricle its usual rate is about 30 per minute, and it is, therefore, likely that any regular ventricular contractions at this rate are produced by impulses arising in the ventricle itself. Hence it is probably correct to assume that during these periods there was complete dissociation between auricular and ventricular contraction, a dissociation, in fact, similar to that occurring in Case 1, differing fron it only in the fact that in the latter case the condition was permanent, while in the case under consideration it was only temporary.

Atropine sulphate was then given subcutaneously in increasing amounts. The smaller quantities had little effect in raising the pulse rate, but when a dose of 1/40 gr. was reached, the ventricular rate was almost doubled, and the heart block disappeared completely.

The patient was discharged early this year, able to walk about without dyspnœa, but compensation broke down a few weeks later and he was re-admitted. During his last stay in hospital, jugular tracings and electro-cardiograms were taken on several occasions, but there was never any return to the idio-ventricular rhythm.

This case raises a question of considerable therapeutic importance. There is no doubt that it is in auricular fibrillation that digitalis produces its most striking effects, and this is true, not only in cases where there is cardiac failure, but also in cases where compensation is well established. Every patient with this type of irregularity has an optimum pulse rate, some patients finding that they are most comfortable with a pulse rate of 60, others with a pulse rate of 70, and so on. On the other hand, in nearly all cases of fibrillation which have been examined post-mortem disease of the conducting fibres of the heart has been found, and it is in these cases that digitalis is apt to produce heart block. It may be that a certain degree of heart block is beneficial, but there are cases on record of auricular fibrillation in which the patients had heart block causing attacks similar to those of Stokes Adams disease.

Since this is the case, all heart block produced by digitalis must be viewed with apprehension because of its liability to produce these seizures, and our object in treating these patients should be to obtain the good results of digitalis without running the risk of producing a dangerous degree of heart block. In this case this was accomplished by giving atropine in addition, and it is possible that some combination of digitalis and atropine would meet the difficulty sometimes encountered in the treatment of these cases. Some observations on this point have already been made, but the question still requires further investigation.

Case 3.—The patient was a boy of 9. There was no history of rheumatism. The boy had been admitted to hospital on two previous occasions for cardiac failure. On admission he was slightly dyspnœic, but his colour was good and he was in no great distress. There was no anasarca. The pulse was 110, regular, but of rather small volume. The apex beat was in the sixth space, half an inch external to the nipple line. The first sound was loud and systolic and diastolic murmurs were heard in the mitral area. The liver was pulsating, and its edge was palpable three inches below the costal margin. Bubbling râles were audible at both bases. The urine was dark in colour, and had a specific gravity of 1020, and contained a trace of albumen. He was given tincture of digitalis, m. vii., every four hours, and improved to a considerable extent.

A few days after admission his pulse became rather irregular, and electro-cardiograms showed that this irregularity was due to partial heart block, the ventricle failing to respond to every auricular beat. An increase of the amount of digitalis increased the degree of heart block, and tracings taken from the apex showed that one beat was dropped in every four or five. Atropine sulphate, gr. 1/200, was then given subcutaneously, and an hour later the heart block had completely disappeared. Two hours after the injection the heart block had returned.

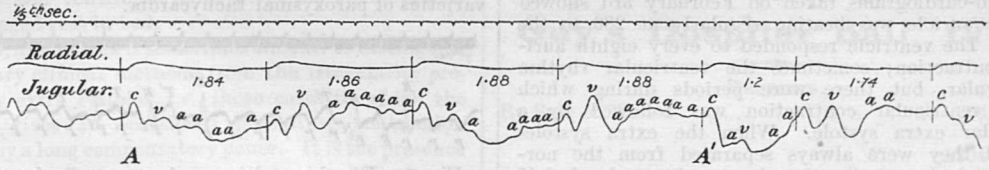

Fig. 4.—Radial and jugular tracings from Case 2. The vertical lines mark the beginning of ventricular systole. The numbers (1·84, 1·86, etc.) indicate the time in seconds between each ventricular contraction. C and V are the carotid and ventricular waves. The normal auricular wave is replaced by a number of small oscillations (a, a) which represent the fibrillary contractions of the auricles. From A—A' the ventricle was beating almost regularly at 32 per minute, and during this period it is probable that complete heart block was present.

The use of atropine in heart block has already been mentioned. In this case a small dose completely abolished the heart block, for a time at any rate. This result is in contrast to cases 1 and 2; in the former, atropine was given without any result, in the latter a large amount had to be administered before any effect was obtained.

Case 4.—The patient was a man of 60. There was a doubtful history of syphilis; ten years previous to admission he had a severe attack of smallpox. In the middle of October, 1912, he had influenza, and his health had never been very good since, but it was not until Christmas, 1912, that he developed any definite cardiac symptoms. About this time he began to suffer from cough and severe dyspnœa on exertion, and was

advised by his doctor to remain in bed. He had never had any œdema or præcordial pain.

He came into hospital on January 15th. He was a well-made, healthy-looking man, in no pain, but evidently in a good deal of respiratory distress. The pulse was rapid, and irregular both in rhythm and volume. The apex beat was in the sixth space in the nipple line. The deep cardiac dulness started just external to the apex and extended to a point three quarters of an inch to the right of the sternal margin. The heart sounds were faint, and there was a soft systolic murmur in the tricuspid area. He had signs of a generalised bronchitis. There was no œdema, the urine was normal, and the liver was not enlarged.

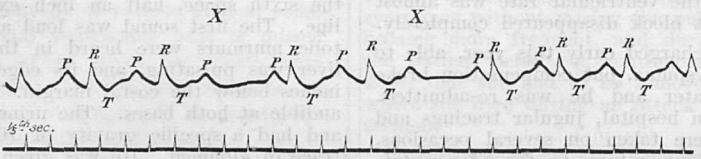

Fig. 5.—Electro-cardiogram from Case 3. Nine auricular waves are shown; seven are followed by ventricular contractions, but two (at X) are "blocked," *i.e.*, they fail to produce any ventricular response.

He was given 15 minims of digitalis three times a day, and at the end of a fortnight was able to sit up in a chair.

Electro-cardiograms taken on February 3rd showed that the auricle was beating regularly at 286 to the minute. The ventricle responded to every eighth auricular contraction; sometimes the ventricular rhythm was regular, but there were periods during which normal ventricular contraction was followed by a ventricular extra systole. When the extra systoles occurred they were always separated from the normal ventricular contraction by an interval of 0·45 seconds. Jugular tracings taken two days later showed that the ventricle responded, as a rule, to every eighth auricular beat, and sometimes to every sixth. All the subsequent examinations were electro-cardiographic.

On February 6th the effect of exercise was investigated, curves being taken before and after the patient had walked a few paces. The auricular rate was not affected, but remained at 286. Before exercise the ventricle responded to every eighth auricular contraction, and every normal beat was followed by a ventricular extra systole 0·45 seconds later. After exercise the ventricle responded to every sixth auricular contraction; the extra systole occurred as before. On February 9th the rhythm had changed completely; the curves showed that the auricular rate was 75, and that the heart's contraction was starting from the normal point.

No curves were taken between February 6th and February 9th, but no gross irregularity of the pulse was noticed during these three days, so presumably auricular fibrillation did not occur. The auricular rate was now increased by exercise in the usual manner, the digitalis was omitted, and during the succeeding fortnight the effect of injections of strychnine and pituitary extract were observed, but nothing affected the presence of the extra systole which continued to occur at the same interval after every normal ventricular contraction.

This is, perhaps, the most interesting case of the four. The first example of this type of heart block was reported by Drs. Hertz and Goodhart about four years ago (2). Only about half a dozen cases were described during the next three years, but towards the end of last year Dr. Lewis published a paper reviewing the cases of other observers and adding a detailed description of nine others which he had investigated himself (3).

This remarkable type of cardiac action is quite unlike any other form of disordered rhythm. Its chief characteristic is the very rapid auricular rate; it varied in Dr. Lewis' series from 200 to 330 per minute.

The degree of heart block is variable; if the ventricle responds to every other beat the pulse-rate is very rapid and the condition affords an example of one of the varieties of paroxysmal tachycardia.

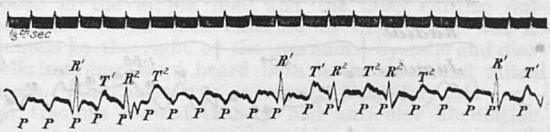

Fig. 6.—Electro-cardiogram from case 4, showing the rapid auricular rate. The P waves occur regularly at the rate of 286 per minute. Three normal ventricular contractions are shown (R^1 T^1) separated by eight auricular beats, the last of which alone evokes a ventricular response, all the preceding ones being blocked. The first ventricular contraction is followed by one extra systole (R^2 T^2), the second by two extra systoles.

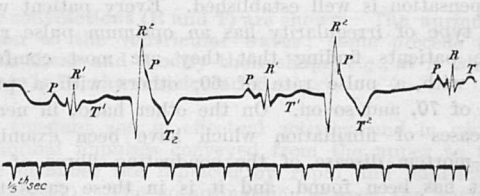

Fig. 7.—Electro-cardiogram from Case 4, taken after the normal auricular rhythm had been restored. Two normal ventricular contractions (R^1 T^1) are shown, each followed by an extra systole (R^2 T^2). An auricular wave falls upon the extra systole in each case.

The pathology of the condition is still obscure since no cases have been examined post-mortem, but it is probable that the vagus plays some part in producing the condition, since the degree of heart block is increased by pressure on the vagi and diminished by atropine. Dr. Lewis advocates treating these cases with digitalis in large doses, and persisting with it until auricular

fibrillation is produced; the digitalis is then discontinued and in many cases the heart resumes its normal rhythm. I have pointed out that in the case described there is reason to believe that the auricle never passed through the intermediate stage of fibrillation, so that in this respect the case appears to be unique.

Heart block of any degree is always a serious affection; even the lesser grades must be viewed with anxiety for, just as in other varieties of heart disease, the lesion is apt to be progressive. Simple delay in the transmission of the stimulus may develop into partial heart block, and there is reason to believe that this in turn may develop into complete heart block, with all the symptoms characteristic of Stokes Adams syndrome. The early diagnosis of these conditions is therefore a matter of considerable importance, and within the last few years it has been shown that disease of the auriculo-ventricular bundle is by no means uncommon.

The recognition of acute inflammation of the heart muscle must profoundly modify the treatment of any disease. In the absence of obvious cardiac dilatation the diagnosis of rheumatic myocarditis is often a matter of difficulty, and in these cases graphic methods are of the greatest value, for they may afford the sole evidence of disease of the myocardium. The discovery of dropped beats, or even mere increase in the interval between auricular and ventricular contraction, is an indication for prolonged rest in bed.

Finally, heart block is sometimes difficult to distinguish by ordinary clinical methods from the irregularity produced by extra systoles, *i.e.*, those cases in which the ventricle gives an occasional premature contraction followed by a long compensatory pause. It is the presence of this pause that sometimes leads to difficulty in distinguishing the two conditions. Accurate diagnosis is here essential since the prognosis and treatment is entirely different in each case. Dr. Mackenzie, writing on this point, says, "I have followed these cases (of extra systoles) for many years, and watched them pass through seasons of sickness and stress, and have seen no reason to attach any serious import to this symptom" (4). The exact significance of extra systoles has not yet been determined, but it is quite certain that in the absence of other signs of heart disease patients with extra systoles may be allowed to take an ordinary amount of exercise, and it is probable that they need not be forbidden the severest forms of muscular work. On the other hand, any evidence of impairment of the conducting mechanism of the heart denotes the presence of very definite disease, and disease of a kind which may develop into one of the most serious forms of myocardial degeneration.

In conclusion, I wish to thank Dr. Pitt, Dr. Shaw, Dr. Fawcett, and Dr. French for permission to publish these cases.

G. H. HUNT.

References.

1. Lewis.—Mechanism of the Heart Beat.
2. Hertz & Goodhart.—Quart. Journ. of Med., 1908-9., II., 213.
3. Lewis.—Heart, Vol. IV., No. 2.
4. Mackenzie.—Diseases of the Heart.

Correspondence.

To the Editor of Guy's Hospital Gazette.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—Ed., G.H.G.]

Guy's Hospital Musical Society.

Dear Sir,—The last concert of the session will be held in the Physiological Theatre on Tuesday, May 6th, at 8 p.m. May I remind members, through your columns, that the choral section of the above Society is providing one-half of the programme?

Up to the present the attendances at the practices have been very poor, and unless they improve it will be impossible to do justice to the music undertaken.

This being Mr. Denis Brown's first hospital concert, it is hoped that members will attend more regularly to make it a big success.

H. Q. F. THOMPSON,
Hon. Sec.

Guy's Hospital Ball, 1912.

	£	s.	d.
Receipts.			
By Sale of Tickets	204	1	0
	£204	1	0
By Profit on Ball	42	15	9
	£42	15	9
Expenditure.			
To Prince's Restaurant	125	15	6
Joyce Band	18	18	0
Sidney Smith—Sashes	2	4	0
Ash & Co.—Printing	6	5	3
Cash Expenditure	4	0	0
Secretarial Expenditure	4	0	0
Cheque Book...	0	2	6
	161	5	3
Profit on Ball	42	15	9
	£204	1	0
Guy's Hospital Ladies' Association ...	20	0	0
Guy's Hospital Maternity Samaritan Fund	15	0	0
	35	0	0
Balance at Bankers held over for next Ball	7	15	9
	£42	15	9

Examined with receipts and bank-book and found correct.

22nd April, 1913. W. M. MOLLISON.

Shingles and Chicken-pox.

I have been encouraged by your recent invitations to old Guy's men to give the benefit of their experiences to the Gazette, to bring the enclosed case to your notice. If it serves to stimulate research in the direction implied, I cannot but hope that knowledge may be thereby increased, and in any case certain of the characteristics of Herpes Zoster and varicella may, perhaps, be more forcibly presented to the minds of your readers than might be the case from ordinary text-book descriptions.

Following the examples of others, I beg to submit the following case for criticism:—

On January 27th of this year I received the following telegram from a farmer lately settled in Rhodesia: "Please come first train; wife very ill; fear erysipelas; Scotch cart at station for you." On arriving at the farm I found my patient, a woman rather over 30, in bed, suffering from a typical attack of shingles. The rash extended from the left shoulder to the wrist and had been preceded for about a week by severe neuralgia commencing in the neck and travelling downwards. The temperature on the day the rash appeared was 99° in the morning and 100° in the evening. The left axillary glands were enlarged and tender.

Being 70 miles from the nearest doctor, they had turned in their distress to their family medicine book and had come to the conclusion from the appearance of the vesicles that "erysipelas" would meet the case; hence their anxiety. So much the greater, therefore, was their relief at hearing that their fears were unfounded and at being assured that shingles was a non-contagious disease. Besides the parents there were three children—Celia aged 10, Jack 7, and Walter 5½, and their grandmother who was paying them a visit. I drove back to the station after lunch, and having packed up some ¼ gr. morphia tabloids to be used for the pain, I sat down to wait for my return train to Bulawayo. Happening to have in my bag the *British Medical Journal* for January 11th I took it out, and was glancing through the "Epitome," when, by one of those unaccountable coincidences which happen to all of us, I was confronted with the heading "Herpes Zoster and Varicella." The paragraph was translated from a German clinical paper and described ten cases of shingles which had been followed by chicken-pox in those who had been brought in contact with the first named affection, and in every case within the prescribed period of incubation of the latter disease.

So impressed was I, not only by the coincidence, but also by the nature of the facts brought forward to prove a connecting link between the two diseases, that I immediately wrote a note to go with the tabloids, warning the patient that though unlikely, it was just possible, that her attack of shingles might be followed by chicken pox in the children.

A week later I received a letter, dated February 8th, to the following effect: "Celia has not been at all well; she complains of pain behind her ear, severe headaches, etc., and seems very feverish, and has bad nights. . . My herpes is much better than it was, but I am afraid I must be a bad patient, and get very impatient of the constant pain in my arm and shoulder which will not allow me to sleep and makes me dreadfully irritable, I'm afraid. It is almost three weeks since I first felt the pain, so I hope it has not much longer to run. We were on the look-out for chicken-pox in Celia as she had one or two suspicious looking 'bubbles' on her body, but there are no further developments of the kind, and she seems better."

A day later (February 9th) the husband wrote: "Last night my wife would have been able to sleep more comfortably had the children not been so restless. All three of them have succeeded in contracting chicken-pox, so we are quite lively. Celia has a fine crop of pock marks, and we are anxious about her, as her throat is giving her a great deal of pain, and she is unable to swallow."

On hearing this I made strict inquiry for any possible source of infection, but was assured:—

1. That none of them had been away from the farm that year.

2. That only two visitors had been there; students from the cape, who, on being written to, assure me that though they had chicken-pox when quite young, they had neither of them been in contact with any cases lately.

3. That none of the natives working on the farm had lately had chicken-pox; they were well acquainted with the disease, and some had had it years ago.

And, finally, it seemed to me an analogous case to those mentioned in the *British Medical Journal*, and to have been a direct infection from the mother's shingles.

For the purposes of comparison I will just mention the chief points of the German cases already referred to. The most convincing was that of a patient admitted to hospital on October 29th with lumbo-femoral herpes. On November 9th another patient suffering from a tumour of the spleen developed varicella. A doctor's wife had an eruption of shingles on the left side of the chest on May 6th, and on May 16th her six-year old daughter developed typical varicella. This woman had never had chicken-pox, but when 4 years old had not been isolated from her two sisters while they were suffering from it. In another family one child suffered from typical Herpes Zoster of the chest, and the other developed typical varicella ten days

later. In the course of 26 years Bokéy saw eight similar cases, the periods between the appearance of herpes and of varicella ranging from eight to twenty days, and in none of these cases was any source of infection other than herpes demonstrable.

I am inclined to think the argument fairly strong in the Rhodesian cases, as the farm is so isolated (10 miles from the nearest railway station and 3 miles from the next farm), that any source of infection should be comparatively easily traced.

Additional points worthy of notice in this latter case are:—

1. The mother had had chicken-pox when 16 years of age. The children had never had it before.

2. All three children slept in the same room as the mother (Celia in the same bed).

General points of interest are:—

1. Dr. Dukes, of Rugby, gives 14 to 19 days as the incubation period of chicken-pox. All the cases agree in having started within this period after the herpes had first made its appearance.

2. Both diseases are first papular, then vesicular in nature, and behave similarly (*e.g.*, in the after-scarring), herpes being apparently concentrated over the course of a nerve, and being, therefore, more severe in character; varicella being universally distributed, and therefore less severe in any one spot.

3. Adamson says, "The clinical features of Herpes Zoster, the sudden onset, the definite course, and the infrequency of occurrence, suggest an infectious disease."

4. If the link between the diseases be clearly established can we any longer define Herpes Zoster as "an acute non-contagious dermatitis," and should we not isolate cases in future?

5. What about the possibility of other micro-organisms acting differently in different constitutions, and under different circumstances producing two apparently different diseases?

I await criticism, but if I am to be put off with the answer, "Pooh, mere coincidence!" then I must humbly beg to be allowed to retain my own opinion.

Railway Medical Officer, W. P. Le FEUVRE,
B. & M. & R. Rly. (At Guy's in the '80's).

Types of Intestinal Stasis.

The following cases serve to illustrate some of the various groups of symptoms met with in chronic intestinal stasis, and the ideal results obtained when the abdomen remains free from inflammatory adhesions.

1. E. L., aged 28, hospital nurse, admitted Nov. 3rd, 1911, under Dr. Hertz, for constipation since infancy which necessitated the constant use of purgatives. At fifteen she had an attack of abdominal pain simulating acute obstruction, followed at intervals by similar attacks during which there was pyrexia, and the patient was acutely ill, and had been diagnosed as typhoid and appendicitis. During eighteen months previous to admission all symptoms had increased in frequency and intensity. Constant headache, flatulence, and thirst were very troublesome, and during the acute attacks great pain, distension, and vomiting were the main symptoms. On examination, fæcal masses could be felt in the iliac colon and lower part of the abdomen. The end of the ilium could be rolled under the finger on deep palpation.

Bismuth, oz. ii., was given in a meal, and after ten hours most of it was in the terminal coils of the ileum, which were situated in the pelvis; the remainder (about one-third) was in the cæcum and ascending colon. After thirty-four hours the bismuth had left the ileum, *but had only reached the hepatic flexure. After fifty-eight hours*, bismuth in cæcum, ascending and first part of dropped transverse colon. After eighty-two hours, no advance.

Treatment: Pil. Col. et Hyos., grs. xvi., with scarcely any effect; electrical treatment; alternate oil and water enemata night and morning, paraffin with every meal, and various other mixtures proved of no avail; so Dr. Hertz advised operative treatment.

September 22nd, 1911. Mr. Lane operated, and found a very well-marked ileal kink and large cæcum, transverse colon dropped and colic flexures very acute; left ovary involved in adhesions. The appendix was removed and a short circuit performed.

Seen in February, 1913. The patient is now married. She takes paraffin, and the bowels act daily. She is entirely free from all the symptoms complained of previously, and has been so since the operation.

This case illustrates very well the obstructive type. The overloaded cæcum and transverse colon cause marked kinking (i.) of the ileum by the formation of an accessory ligament; (ii.) of the colic flexures due to the pull of the transverse colon. Here the most thorough and skilled medicinal treatment had failed because it could not overcome a mechanical obstruction. Although not so marked as in some cases, the symptoms due to toxæmia were quite definite, and were relieved by diminishing the time allowed for absorption of toxic substances from the intestines.

2. K. C., aged 44, was admitted to Martha for abdominal pain and constipation since childhood.

History: When seven had tuberculous knee with sinus formation lasting seven years. From 15 to 25 was always suffering from "minor complaints." At 27 developed phthisis, and at 29, mucous colitis, for which she was treated with success, but later the right kidney became moveable, and she was forced to wear a belt. At 37 she developed exophthalmic goitre which got well after prolonged treatment. Two and a half

years ago the colitis again returned and has continued with more or less severity ever since. For the last six months there has been much pain in the right iliac region.

On admission there was marked tenderness and thickening of the ileum, a large, dropped cæcum, the abdomen generally being tender. She had lost a great deal of flesh, and was markedly pigmented.

X-ray report: After seven and a half hours some bismuth still in stomach, the rest chiefly in the terminal coils of ileum, traces in cæcum and ascending colon. After 56 hours, some bismuth in dropped transverse colon, the rest in the rectum.

At the operation Mr. Lane demonstrated a marked ileal kink and a distended and hypertrophied duodenum. The bad condition of the large intestine necessitated its removal, the ileum being joined to the pelvic colon.

On discharge, the patient's colour had improved, she had no pain and felt considerably better; had been eating meat for the first time for two years.

March 22nd, 1913. The patient writes: "I do not know how to express my great thankfulness and gratitude for all that has been done for me. . . Life is already different. For the last fortnight I have walked from a quarter to half a mile, and, indeed, often get out twice daily; consequently my appetite is splendid, and I seldom remember how I sleep, it is so deep and healthy as compared with last and many previous years. Those of my friends who have seen me are astonished at the marked difference in my appearance."

This case shows well a state of both local and general toxæmia. The state of chronic ill-health, liability to tubercle and exophthalmic goitre, may be attributed to this cause. Symptoms of obstruction were, in this case, overshadowed by the toxic symptoms, but the presence of obstruction was proved by the delay of the bismuth both in the stomach and ileum. The short circuit served to drain the small intestine, and the removal of the large bowel precluded the possibility of any further absorption of toxins from it and the recurrence of colitis.

Of course, it is early yet to say that adhesions will not form, but I think the disappearance of the toxæmia is sufficient in this case to justify the operation, especially as all other treatments had failed to produce any permanent benefit to her general health, and, looking at the result from the patient's point of view, she is delighted. G.

Pupils' Physical Society.

A Meeting of this Society was held on Wednesday, April 16th, in the new Pathological Theatre. Sir James Goodhart, Hon. President, occupied the chair, and about a dozen members were present. The minutes of the previous meeting having been read and confirmed, the President then called upon Dr. W. A. Aikin to read his paper upon the Science of Phonology. Dr. Aikin illustrated his paper, which was exceedingly interesting, and embodied much that was quite new to his hearers, with laryngoscopic views of his own throat.

The meeting concluded with a vote of thanks to Dr. Aikin, moved by Dr. Hale White, and seconded by the Hon. Sec.

Guy's Hospital Past and Present Nurses' League.

The Fifth Annual Dinner and the Eleventh Annual General Meeting of the Guy's Hospital Past and Present Nurses' League was held in the Nurses' Home on Friday, 18th April, 1913.

About 110 members sat down to dinner in the dining-hall, the tables looking very pretty with their floral decorations of spring flowers, thanks to the energy of the Home Sister, Miss V. Lulham, who is to be congratulated upon the very successful way in which everything was carried out.

Among those present were:—The Matron, Mrs. Browning, Mrs. H. C. Cameron, Miss Finnis, Mrs. Henderson, Mrs. Higgens, Mrs. Hinchliff, Mrs. Hughes, Mrs. Lance, Mrs. Poolman, Mrs. W. G. Stewart, Mrs. Wickham, Miss E. Densham, Miss A. Fricker, Miss Hall, Miss Hoadley, Miss Oxford, Miss Rowell, Miss Swift, Miss A. Wilkinson.

After dinner, tea and coffee were served in the Hall, and many other members who were unable to be present at the dinner joined the party and renewed old acquaintance.

The meeting was held in the Nurses Recreation Room, Miss M. N. Oxford taking the chair. The Hon. Secretary gave an excellent report of all the different sections of the League, and in the absence of Mrs. Fagge, the Hon. Treasurer, made the financial statement, which was also most satisfactory.

The ballot for the election of Members of Council was announced as follows:—

Nurses' Choral Society.—Sister Light and Nurse E. M. Fletcher (re-elected).

Nurses' Debating Society.—Sister Lydia (re-elected) and Nurse Angove.

Nurses' Hockey Club.—Sister Naaman and Nurse Warner.

Nurses' Library.—Sister Job and Nurse Brown.

Nurses' Tennis Club.—Sister Doris and Nurse Marshall.

Nurses' Swimming Club.—Sister Olive and Nurse Macdonald.

Nurses' Photographic Society.—Sister Addison (re-elected) and Nurse Hughes (re-elected).

The meeting was next asked to confirm the election of Hon. Members of Council: The Hon. Mrs. Molyneux, Lady Perry, and Mrs. H. C. Cameron, the three members retiring in rotation this year being the Countess of Bective, Mrs. Arbuthnot Lane, and Mrs. Hale White, to whom the Nurses' League is much indebted for valuable help and advice.

Votes of thanks to the Hon. Treasurer, the Hon. Secretary, the retiring members of Council, and to Miss Oxford for presiding, terminated the business meeting, after which songs and music by present members made a pleasant accompaniment to the general buzz of conversation.

The Tenth Annual Exhibition of the Nurses' Photographic Society was opened in the afternoon in the presence of the Countess of Bective, Mrs. Cosmo Bonsor, Mrs. Cameron, Mrs. Fagge, Mrs. Forsyth, Mrs. Ormond, Mrs. Rowlands, Mrs. Shaw, Mrs. Steward, Miss E. Bonsor, Miss Swift, and other Hon. Members.

The photographs, numbering over 160, were placed on screens covered with brown canvas, and edged with a narrow piece of dark wood to give the impression of a large frame, which proved a very effective setting. Mr. F. T. Hollyer again kindly judged the exhibits, and expressed himself very pleased with the great improvement shown in the photographs this year, there being many more enlargements, which showed the photographs to a better advantage.

Mr. Hollyer made the following awards, which were placed at his disposal by the Countess of Bective, Mrs. Cosmo Bonsor, and Mrs. Trevelyan Martin:—

Class A (for those who have won an award at a previous exhibition).—1st Prize, No. 18, Sea and Cloud, Sister Addison. 2nd Prize, No. 56, By the Burn, Miss J. Paterson. 3rd Prize, No. 3, On Lago di Como, Miss M. C. Fisher.

Class B (for those who have not won an award).—1st Prize, No. 7, Thirlmere, Nurse Webster. 2nd Prize, No. 3, Off the Coast of Arran, Nurse Frank. 3rd Prize, No. 11, Mohammedan Cook Woman, Miss A. Wilkinson.

Class C (for photographs not the entire work of exhibitor).—1st Prize, No. 15, Cloisters, Norwich Cathedral, Mrs. C. H. Wells. 2nd Prize, No. 26, A Street Scene, Srinagar. Sister Kate Webb. 3rd Prize, No. 10, David, Mrs. Forsyth.

Special Prize for best picture in the Exhibition—Sister Addison.

Special Prize for best picture by Present Member working in the Hospital—Sister Addison.

(These Prizes both taken by No. 18, Class A, entitled "Sea and Cloud.")

The following photographs were highly commended:

Class A.—No. 5, Washing bullocks after work, Miss Fisher. No. 7, Sunset from Varenna, Miss Fisher. No. 10, The road to the mill, Miss A. M. Phillips. No. 16, Nell.

Class B.—No. 21, The Lighthouse, Nurse A. Hawkins. No. 18, Snapshots in Switzerland, Miss E. Skinner.

Class C.—No. 27, The Lotus Flower, Sister Kate Webb. No. 32, Ruins of a Kashmir Temple, Sister Kate Webb.

NEEDLEWORK EXHIBITION.

A new innovation in connection with the Nurses' League was the Needlework Exhibition which was held simultaneously with the Photographic Exhibition. One hundred and six pieces of work were sent in by Past and Present Members, consisting of lace, embroidery, silk embroidery, church embroidery, crochet, drawn-thread work, plain needlework, etc. The arrangement of the work was placed in the hands of Sister Naaman, Miss K. New, and was most effectively displayed in glass cases and on tables.

Prizes were placed at the disposal of the judge by the Matron, Mrs. Fagge, Mrs. Lane, Mrs. Shaw, Mrs. Hale White, and Miss E. Bonsor. Mrs. Burgwin, the Inspector of Special Schools under the L.C.C., kindly judged the exhibits and made the following awards:—

Darning and Patching.—Nurse Boys, prize.

Crochet.—Nurse A. M. Ward, prize; Nurse Yewdall, very highly commended.

Plain Needlework.—Nurse Carr Hill, prize; Miss E. M. Cooper, Aylesbury, commended.

White Embroidery.—Sister Astley Cooper, Miss Gimson, prize; Sister Winifred Venning, commended.

Lace: Carrickmacross applique.—Nurse Staines, prize; Carrickmacross Guipure—Nurse McElroy, prize.

Drawn-Thread Work.—Sister Rebecca Ford, prize.

Hardanger Work.—Sister Naaman, Miss K. New, prize; Miss Victoria Jones, commended.

Church Embroidery.—Nurse Drower, very highly commended.

Adrenalin in Chloroform Anæsthesia.

By H. T. DEPREE, M.B., B.C.,
Resident Anæsthetist, St. Mary's Hospital, W.

THE following case seems to be worth publishing if only to emphasise a very real danger which is, perhaps, not as widely recognised as it should be.

The patient was a male, aged 26, a well-developed and healthy man. Urine contained nothing abnormal; heart sounds normal; proposed operation for deflected nasal septum. Anæsthesia was induced by chloroform,

given upon a Skinner's mask, the induction taking about seven minutes, with no struggling. The patient was transferred to the operating table, and it was decided to inject some adrenalin subcutaneously into the nose. At the time of the injection anæsthesia was light, a brisk corneal reflex obtainable, the pulse strong, and patient's colour good; no more chloroform was given. About one minute after the injection the pulse suddenly became very rapid and then imperceptible, at the same time the patient became a peculiar leaden grey colour, and the pupils became widely dilated. About three deep gasps were taken after the pulse had ceased, and then respiration stopped.

The head was at once lowered, artificial respiration performed, 1 c.c. of pituitary extract administered hypodermically, and oxygen given. Finally, an incision was made along the left costal margin and the heart massaged through the diaphragm, but to no purpose. About 5 minims of a 1 in 1000 solution of adrenalin was used for the injection. The nostrils had been plugged about ten minutes before the induction of anæsthesia with a solution containing cocaine (10 per cent.) and adrenalin.

At the post-mortem nothing abnormal was found in any of the organs.

In the *British Medical Journal* of September 14th, 1912, Dr. A. Goodman Levy published the results of experiments which he had made upon cats with injections of adrenalin under chloroform anæsthesia. He found that when anæsthesia was light, after the injection of small doses of adrenalin into a vein, a definite series of events followed: the heart first beat more forcibly and rapidly, but then inco-ordinately and finally ceased, the effect of the injection being to bring about "fibrillation of the ventricles."

Under deep chloroform anæsthesia the effect was much less marked, and passed off after a few moments, the heart again beating regularly. Under ether anæsthesia none of these effects were noticed. The case quoted above seems to correspond exactly clinically with Dr. Levy's experimental work.

In the Proceedings of the Royal Society of Medicine, February 3rd, 1911, Dr. Blumfeld describes a case of sudden collapse following the injection of m. vi. of a 1 in 4000 solution of adrenalin in a patient anæsthetised with C.E. mixture. In this case, however, the patient recovered after the employment of remedial measures. If an injection of adrenalin be made just before an anæsthetic is given no bad results occur.

It is difficult to understand the fact that when chloroform anæsthesia is deep the danger of injecting adrenalin is less than when light; unfortunately, in those operations in which adrenalin is most often used for hæmostatic purposes—those about the nose and throat—it is a light anæsthesia that is desirable, and the anæsthetic chosen is usually chloroform.

A Retrospect.

Now that the Medical School stands completed it is a pleasant task to look back upon the stages of the work. In 1897 the Physiological Buildings were opened and in 1903 the Wills Library was built. In 1904 the Anatomical Department was rebuilt and extended to meet the growing needs of the student. The year 1905 saw the Biological Department and the Gordon Museum completed. In 1910 the Departments of Chemistry and Physics respectively were built. Since then the Dental School has been rebuilt and extended (1912), and the completion of the Department of Pathology has marked the end to the great scheme. It is interesting to read the speeches made in 1897 at the opening of the Physiological Department, and to note how the various stages in the full development of the school were foreshadowed. Dr. Pye-Smith said :—

"While in every cilivised country except England and the United States the training of physicians and surgeons is provided for by the Government as part of its duties, our profession like those of the Church, the Law, and Engineering, provides for itself and for the public. The schools of medicine in London have formed themselves around the great hospitals and have only gradually acquired their present importance and repute.

"Apart from the practical instruction in the wards of the hospital, some knowledge of natural science has always been included in the preparation for a liberal profession like that of medicine; physicians have always been botanists and chemists, surgeons have always been anatomists. During the last fifty years great has been the development of these preliminary scientific studies, the indispensable foundation of rational medicine. We have not only lectures on physics, on chemistry, and on biology, but well-equipped laboratories for each of these subjects, in which our students become practically familiar with scientific facts. We have twice rebuilt or greatly enlarged our museums and laboratories since the old buildings were erected in 1826. We have now laboratories for physiology, for clinical chemistry, for histology, and for the new science of bacteriology. But, again, as our numbers increase and the progress of science goes on, we must pull down our barns and build greater. In medical science, as in a still more important discipline, the Augustinian saying is true, *qui satis dixerit, perditus est.* We must go on if we are not to fall back. Accordingly, after repeatedly considering various

plans for enlarging and remodelling the old museum and laboratories, we determined that none of them was satisfactory and that we must at least erect a new building for the important department of physiology, not comparable to the magnificent palaces which are called 'Institutes' at Berlin and Strasburg, but fitted for the best possible teaching and the most advanced researches.

"This part of the more extensive future block of museums and class rooms is now completed. Immense labour has been bestowed upon it, similar institutions in this kingdom and on the continent have been visited and studied by our lecturers, and the result is what we have every reason to believe will be useful for another fifty years. Two names among the many to whom the school is deeply indebted demand particular mention, those of our architect, Mr. Woodd, and Dr. Shaw, the Dean of the Medical School.

"It is only right to explain how the necessary funds were raised. Your Royal Highness knows well—none better—the sad losses of rents which have compelled the Governors of Guy's Hospital to close some of their wards. We know, too, and shall never forget how you came to their help, and how by your generous and practical aid the prospect of further curtailment of the charity was banished and replaced by a hope that before long its closed beds may be re-opened to the public. The treasurer of the hospital could not give, and we could never ask for any help from the hospital funds. Every pound given to Guy's Hospital is devoted to the direct relief of the patients. The school does not receive from, but gives to, the hospital, with which its prosperity and almost its existence are closely united. It is needless to say that the Government does not help medical science as it does on the continent, and our rich men are only beginning to learn to devote their wealth to founding colleges and laboratories and observatories, like those which do honour to our kinsmen across the Atlantic. Only one resource remained open, and we determined to appeal to ourselves. We made a collection, all giving something as he was able, and with the money thus subscribed the present institute was built.

"Here physiology will be zealously and efficiently taught and fresh knowledge will be acquired. The old laboratories, where Sir William Gull, Dr. Pavy, Mr. Golding-Bird, and the late Dr. Wooldridge worked, will hand on a good tradition of industry, intelligence, and zeal to their successors—and the benefit will not be only for our students, but for the whole community. Such institutes are too few; for they are not only 'light bringing but fruit-bearing'; they not only form the foundation of scientific and efficient treatment of disease, but are the source whence spring such discoveries as bless the whole world, and crown with the gratitude of nations the names of Jenner, of Simpson, of Pasteur, and of Lister."

And the late King Edward, then Prince of Wales, in his reply told his audience:—

"Looking back upon the history of this school, one cannot but admire the wonderful powers of observation which enabled such men as Astley Cooper, Bright, Addison, Hodgkin, and Gull, with but slender aid from scientific apparatus, to add so largely to the sum of human knowledge. I need hardly remind you that more than one of these great workers in your profession has had his name perpetuated in connection with the discoveries he made in the wards of Guy's Hospital—discoveries which paved the way for the more enlightened treatment of some of the most frequent and yet most fatal diseases to which man is subject. That harvest has been gathered, and for the present and future generations it remains, with more exact appliances and more delicate apparatus provided by the sister sciences, to seek on other fields to emulate their illustrious predecessors' example. To this end are needed ampler buildings, specially designed rooms, and complicated mechanical contrivances, all of them involving additional expenditure. Your senior physician has made it clear to all how, relying upon themselves, the staff of the medical school have erected this building. I may be permitted to emphasize the fact, to which Dr. Pye-Smith has alluded, that the present building is but an instalment of a more extensive design which is to be completed as soon as funds are forthcoming."

That hope has now been realised. Every department that a modern hospital can require is now set up—each a whole by itself. As time goes on there may be room for improvement in equipment, and, with the continual need for new apparatus which the advance of science calls for, such improvement must be made; but we have now the main essentials. There can be no doubt that in the future the physician will come to depend more and more upon his laboratory, and it is a grand thing that the efforts of the authorities of the Medical School and the generosity of the Subscribers should have made it possible for this need to be anticipated. Guy's men can proudly and gratefully claim a school, not only glorious in the great men which it has produced, but also rich in the possibilities of future greatness.

Pass List.

First Conjoint Examination, April, 1913.

Part I.—Chemistry.	Part II.—Physics.
R. Aspinall-Stivulu.	*C. Vincent-Brown.
*C. Bethencourt.	E. M. Webster.
*W. R. G. Hearnden.	B. C. Woodroffe.

*Passed in Part I. only.

Part III.—Elementary Biology.

R. Aspinall-Stivulu. | K. F. McAlpin.
K. M. K. Duff. | A. Magill.
G. E. L. Simons.

Part IV.—Practical Pharmacy.

F. W. Crook. | H. S. Groves.
K. M. K. Duff. | T. W. Sheldon.
P. Green. | A. H. Taymour.
G. W. Wheldon.

Second Conjoint Examination, April, 1913.

Anatomy and Physiology.

G. L. Cutts. | E. A. Leviseur.
J. Kyle. | E. M. Litchfield.
G. S. B. Long.

Royal College of Surgeons of England.

Licence in Dental Surgery.

Preliminary Science Examination, April, 1913.

Part I.—Chemistry. Part II.—Physics.

J. Alcée. | H. O. Long.
H. J. Barrand. | A. E. Lowein.
*J. F. Batsford. | R. A. Moore.
†P. E. Bernhard. | J. C. Robertson.
†E. H. Bryant. | *S. Sanders.
L. H. Dixon. | †D. F. Small.
†N. V. Stebbings.

*Passed in Chemistry only. †Passed in Physics only.

Papers by Guy's Men.

C. W. Chapman, M.D.: Review of the Literature of Heart Disease.—*Practitioner*, April, 1913.

Stanley Denyer, C.M.G., M.D. Cantab., F.R.C.S.: A Note on the Use of Sugar in Heart Disease.—*Lancet*, 19th April, 1913.

A. F. Hertz, M.D., F.R.C.P.: Chronic Intestinal Stasis. Read at the adjourned Discussion on Alimentary Toxæmia at Royal Society of Medicine.—*British Medical Journal*, 19th April, 1913.

L. W. Reynolds, M.R.C.S.: Note on a Case of Obstinate Sciatica treated by Phenazonum Injections.—*Lancet*, 12th April, 1913.

Sir George Savage, M.D., F.R.C.P.: Automatism.—*Practitioner*, April, 1913.

W. H. Maxwell Telling, M.D., M.R.C.P., and another: Case with Comments. Influenza with Repeated Rigors. *Practitioner*, April, 1913.

R. M. Wormald, L.D.S.: Ionic Medication in Dentistry.—*British Dental Journal*, 15th April, 1913.

Appointments.

Naval and Military.

Lieut.-Colonel G. T. Birdwood, M.D., I.M.S., has been appointed Professor of Pathology on the Staff of the King George Medical College, Lucknow.

A. Neville Cox, M.B., B.S. Lond., has been appointed Tuberculosis Officer to the County Borough of Brighton.

R. A. Greeves, M.B., F.R.C.S., has been appointed Curator and Librarian to the Royal London Ophthalmic Hospital (Moorfields), City Road, E.C.

Staff-Surgeon W. P. Walker, R.N., to *Gibraltar* for *Crescent*.

Captain D. P. Watson, R.A.M.C., has been appointed a Clinical Pathologist at Queen Alexandra's Military Hospital, London.

Colonial Medical Staff.

N. A. D. Sharp, M.R.C.S., L.R.C.P., D.T.M., has been appointed to the Staff (Gold Coast).

Civil.

Montague F. Hopson, L.D.S., has been elected to Board of Examiners in Dental Surgery, Royal College of Surgeons, England.

A. J. MacNair, M.B., B.C., has been appointed Clinical Assistant, Chelsea Hospital for Women.

N. I. Spriggs, M.D., B.S. Lond., F.R.C.S., has been appointed Police and Fire Brigade Surgeon at Leicester.

Birth.

POULTON.—On April 20th, at 21, Belmont Park, Lee, Kent, to the wife of E. P. Poulton, M.B., B.Ch.Oxon., M.R.C.P., a son.

Marriage.

MUNDEN—HUMPHRY.—On Wednesday, April 16th, at the Sub-deanery, Chichester, by the Rev. Prebendary Burdon, W. P. Henley Munden, M.D., second son of Dr. C. Munden, of Ilminster, Somerset, to Doris Mary, younger daughter of Dr. and Mrs. R. Humphry, of Chichester.

Death.

LONG.—At Crowmarsh, Wallingford, on 15th March, 1913, Major J. W. F. Long, retired pay, late R.A.M.C., aged 54.

Ed.—F. G. L. S.

GUY'S HOSPITAL GAZETTE.

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Passim.

AS we announced in our last number, the Right Hon. A. J. Balfour, M.P., a Governor of the Hospital, has consented to open formally the New Buildings comprising the new Laboratories of Chemistry and Physics, the new Pathological Department, and the new School of Dentistry on Tuesday, June 3rd.

The ceremony will commence in the Physiological Theatre about 2.20 p.m. The gallery of the theatre will be reserved for students, and places will be balloted for on May 27th. Applications for places in the gallery should be addressed to the Secretary of the Students' Club before 9 a.m. on Monday, May 26th. No student may receive more than one seat.

Later in the afternoon a Garden Party, to which all Past and Present Guy's Men are invited, will be held, when the new School Buildings will be open for inspection. Past and present students desiring to bring guests, either ladies or gentlemen, should make application for tickets on or before May 26th to the Dean of the Medical School. It is regretted that, owing to lack of space, these invitations cannot admit holders to the ceremony in the Physiological Theatre.

WE congratulate Sir Cooper Perry on having been asked to conduct the recent inquiry into certain alleged irregularities at York County Hospital. We need scarcely point out to our readers that the task before the investigator was a very difficult and delicate one to perform. He had to bring with him, not only a full and intimate knowledge of the details of hospital administration, but also a judicial impartiality, and a very large amount of tact. We congratulate him, but do not envy him.

WE extract the following from a paragraph relating to this inquiry in a recent number of *John Bull*. The italics are our own.

> "In view of the terrible seriousness of this suggestion, the Hospital authorities have asked Sir Cooper Perry, M.D., of Guy's Hospital, to conduct an enquiry into the facts . . . . *Sir Cooper Perry is a surgeon of high repute.*"

Well, of course, "if you see it in *John Bull*—it is so"! But we wonder where the "Super" operates. Perhaps excision is the latest treatment for ringworm and scraping, not scratching, for scabies.

WE publish this week a report of the Annual Dinner of the Guy's Hospital London University Club. It is melancholy reading. Here is a club with a membership of over 200, including nearly half the Staff and many other members living either in town or within easy distance of it. Now one might reasonably expect a club with a membership of such size to be able to show a better attendance at its annual dinner than 21 members and guests altogether. Among these there were only three members from the wards and dissecting-room, and only two members of

the Staff. It is difficult to understand why there should be so much apathy among London University men. That the fault lies with the members of the club and not with the secretaries is shown by the fact that they sent out over 200 circulars announcing the meeting.

There may be some truth in the argument that London men never feel they are co-members of a great Corporation in the same way as men from the other Universities, but at the same time we should have thought that they would welcome the opportunity to meet their contemporaries once a year, quite apart from any special feelings of loyalty to their University.

We feel ourselves that the price of the dinner ticket, 7s. 6d., is one of the chief causes why the attendance is so poor, and humbly suggest to the Committee that they should in future offer their members a dinner for four or five shillings. Men in the dissecting-room and wards do not on the whole think a dinner is worth much more, and we believe that unless the men come to realise what an enjoyable function this dinner is before they leave the Hospital, they are very unlikely ever to turn up afterwards.

ON Monday, May 5th, the first Surgical "At Home" was held at Guy's. The function was a great success, between thirty and forty surgeons from all the teaching hospitals of London attending. A very attractive list of operations was prepared for their delectation, and if one may judge from the way the visitors endured the appalling heat of some of the theatres, they must have been very keenly interested in what they saw. There were sixteen operations put upon the notice board for the day, and more than half the visitors remained to the end.

It is to be hoped that these "At Homes" will become a regular annual feature of London Surgery. "No man is a prophet in his own country" we know, but at the same time we cannot but think that it will be all for the benefit of English Surgery if the surgeons became a little more familiar, not only with their contemporaries' views, but also with their methods. At present, probably, the surgeons of any one of the big hospitals know less about their fellow surgeons in London than they do of the Continental and American surgeons. We were very interested to find, in conversation with many of the visitors on Monday last, how many of them had never before visited Guy's, or at any rate had never been present at any operations here.

THE articles from the able pen of Mr. R. M. Wingent, which have appeared during the past year in the GAZETTE under the title of "London Bridge and the Borough in the Eighteenth Century," are being collected in book form, and will shortly be published under the title of "The Borough and the Borough Hospitals." We are sure there are many Guy's men, both past and present, who will be glad to avail themselves of this opportunity of obtaining these articles in book form. We need scarcely remind our readers what a wealth of historical interest is to be found in these articles, or how much labour they must represent. The book will be published at the price of 3s. to subscribers, and 3s. 6d. to non-subscribers. Orders should be sent to the Manager of the GAZETTE.

WE have received an announcement of an Historical Medical Museum which is to be opened in London in June of this year. The undertaking has been organised by Mr. H. S. Wellcome, and promises to contain many interesting exhibits. We are sure that all physiologists will be keenly interested in a special exhibit of the apparatus used by Galvani in many of his original experiments. We can imagine the thrill of delight which the sight of the first muscle-nerve preparation will cause them.

Many of the exhibits, however, will date back to a period long before Galvani. We note that there are to be collections of Grecian and Roman medical apparatus, and also of the charms and amulets used in English folk medicine.

The Residents "Going-Off" Dinner was held in the College Dining Room, on April 30th. The off-going Residents were Messrs. J. L. M. Symns (President), T. B. Heaton (Vice-President), R. Montgomery, H. L. James, and P. Smith. The new-comers to the table are Messrs. C. R. Gatley (H.-S. to Sir A. Fripp), L. Milton (H.-S. to Mr. Steward), W. S. George (H.-P. to Dr. Hale-White), C. Aldis (H.-P. to Sir Cooper Perry), and W. E. Blake (Junior Charity).

We congratulate Messrs. V. R. Glendining (Mr. Lane's H.-S.), and H. R. Bastard (R.-O. to Mr. Bellingham Smith), on being elected President and Vice-President respectively. The Dinner was of the usual merry type, and several good songs helped to enliven the proceedings.

We offer our hearty congratulations to Messrs. G. Dunderdale and W. E. S. Digby on having secured appointments in the Colonial Medical Service. Both gentlemen are, we understand, going to Africa in a few months. Mr. Dunderdale has been R.M.O.B. for the last two years, and Mr. Digby is resigning his appointment as H.-P. to Dr. Shaw in order to take up his new work. Mr. A. H. Birks has been appointed to the vacancy in his place.

Appointments.

Naval and Military.

Lieut.-Colonel T. B. Winter, R.A.M.C., has taken up duty *pro tem.* as Officiating Assistant Director of Medical Services, Colchester district.

Major J. Matthews, R.A.M.C., has taken up duty at Secunderabad.

Captain A. M. Benett, R.A.M.C., has been appointed Staff Surgeon at Mhow.

Captain D. P. Watson, R.A.M.C., has been appointed Clinical Pathologist to Queen Alexandra's Military Hospital.

Civil.

M. R. Dobson, M.B., B.S., has been appointed Medical Officer to Craiglands Hydro, Ilkley.

R. A. Reeves, M.B., F.R.C.S., has been appointed Curator and Librarian to Royal London Ophthalmic Hospital (Moorfields), City Road, E.C.

Obituary.

William Courtenay Milward, CARDIFF.

William Courtenay Milward, an old Oxford and Guy's man, died very suddenly at Cardiff of angina pectoris, on April 9th, aged 41. Milward went to Jesus College, Oxford, in 1889, took his B.A. in 1893, and his first M.B. in 1894. He entered Guy's in 1895, dressed for Mr. Davies-Colley and clerked for Dr. Goodhart. He took his M.R.C.S., L.R.C.P. in 1898, and started practice in Cardiff in 1902. Early in his career Milward distinguished himself as a rowing man. At Oxford he rowed for his College, and when at Guy's he was a member of the London Rowing Club, and rowed in the London Rowing Club Trial Eights, taking part in one of the last 12-oar races that ever was rowed. After he left Oxford he coached the Jesus boat for two years.

In Cardiff, recently, Milward has done an enormous amount of work for the local profession in connection with the Insurance Act. He was Senior Secretary of the Cardiff Division, B.M.A., Representative of the Division, and a member of the State Sickness Insurance Committee. Undoubtedly, from the nature of his illness, this hard work contributed to his death.

THE MILWARD FUND.

Milward's practice, though arduous, was relatively unremunerative, and his sudden death has left his widow and three children (boys, aged 15, 9, and 2), almost totally unprovided for. The local profession has started a fund, "The Milward Fund," for their benefit, and it is thought that old Guy's men who knew Milward might also like to contribute. Hence the mention of the Fund here. Amongst the donations already received, the following are from old Guy's men:—

	£	s.	d.
Fortescue-Brickdale, John Matthew, Bristol	5	5	0
Cresswell, F. P. S., Cardiff	5	5	0
Davies, F. W. S., Cardiff	2	2	0
Fuller, W. A. Milnthorpe, Westmorland ...	1	1	0
Fripp, Sir Alfred D., K.C.V.O., C.B. ...	5	5	0
Goodhart, Sir James, London	21	0	0
Hind, Wheelton, Stoke-on-Trent	10	0	0
Hacquoil, P., Penarth	1	1	0
Ibotson, E. C. B., Briton Ferry	1	1	0
Lane, W. Arbuthnot, London	2	2	0
Leigh, W. W., Treharris	3	3	0
Lloyd, Morgan, Llanarthney	4	4	0
Lyne-Blight, W., Cardiff	5	5	0

Pearse, Athol J., Cardiff	5	5	0
Ramsden, Walter, Oxford	5	5	0
and £1 1s. per annum for five years.			
Sheen, William, Cardiff...	10	10	0
and £1 1s. per annum for five years.			
Spurgin, H. B., Northampton	1	1	0
Shaw, Lauriston E., London	5	5	0
and £2 2s. per annum for five years.			
Thomas, F. G., Swansea	5	5	0
Ward, Ernest, Merthyr	1	1	0

Further donations, or promises of subscriptions over a period of years, will be gratefully received by the Hon. Treasurer of the Fund, Mr. William Sheen, 2, St. Andrew's Crescent, Cardiff, and will be acknowledged in the Gazette.

Notices.

Medical School Prizes.

Junior Prizes for General Proficiency, 1912-13.

Mr. J. Gaymer Jones, ,, P. G. McEvedy } equal £17 10s. 0d. each.

Michael Harris Prize for Anatomy.

Mr. J. Victory	Prize £10.	
,, P. G. McEvedy	Certificate.	
,, J. Gaymer Jones	Certificate.	

Sands Cox Scholarship in Physiology.

Mr. P. G. McEvedy	Scholarship.	
,, J. Gaymer Jones	Certificate.	

Dental School Prizes.

Second Year's Prize in Dental Subjects.

Mr. W. A. Bulleid ... ... Prize £10.

Second Year's Prize in General Subjects.

Mr. W. A. Bulleid	Prize £10.	
,, E. R. Saul	Certificate.	
,, C. H. Edwards	Certificate.	

First Year's Prize in Dental Subjects.

Mr. J. M. Barnes, ,, D. Clewer, ,, M. G. Whitten } equal £3 6s. 8d. each.

Guy's Hospital,
25th April, 1913.

Royal Army Medical Corps.

ENTRANCE EXAMINATION.

An examination for commissions in the Royal Army Medical Corps will be held on the 23rd July, 1913, and following days. Applications to compete should be made to the Secretary, War Office, not later than 14th July, 1913. The presence of candidates will be required in London from the 21st July, 1913. In consequence of reduction of the garrison in South Africa, it is improbable that more than five commissions will be available.

A copy of the Regulations for admission to the Royal Army Medical Corps and a form of application can be obtained on application to the Secretary, War Office.

Correspondence.

To the Editor of Guy's Hospital Gazette.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—Ed., G.H.G.]

Shingles and Chicken-pox.

Dear Mr. Editor,—With regard to the article on "Shingles and Chicken-pox" in the last number of the Gazette, I should like to relate the following case.

On Tuesday, April 8th, one of my patients travelled from Leeds to Huddersfield by train and was obliged to sit facing the engine, and the carriage window being open, he was exposed to a very cold draught. On the Thursday and Friday he complained of severe pain in his back and below the right scapula, which he compared to bad lumbago. On Saturday morning (April 12th) there was an eruption of vesicles, characteristic of herpes zoster. In the course of a day or two several of these vesicles ran together and formed bullæ, varying very much in size, but all were filled with sanguineous fluid. On Monday (April 14th) this patient, who is over 70 years of age, began with a typical attack of varicella. The chicken-pox vesicles went through their regular stages, and there were scores of them, on the scalp and back especially. Two have left small pits or scars. With regard to the shingles, the bullæ gradually dried up, but unfortunately the skin beneath became gangrenous or at any rate formed sloughs, which are at present slowly separating and leaving healthy granulating ulcers. I have seen and treated many cases of shingles, but this is without doubt the severest that I have ever seen. The pain is described by the patient as being as if he had been cut with the lash and had salt rubbed into the wheals. I have tried to find out whether the patient had been exposed to chicken-pox infection, and we went over his doings and his travels during the previous fortnight but could not fix upon anything which would throw any light upon the matter. Of course, it is quite possible that he may have been exposed to infection in the tram cars which he uses frequently, and if there were any children about he would be sure to take notice of them, speak to them, and perhaps chuck them under the chin. What is remarkable about this case is the age of the patient for an attack of chicken-pox, and this attack being super-imposed on shingles. Is there any possibility of the infection being one and the same?—I am, yours sincerely, F. JORDAN COLEMAN.

60, Spencer Place,
Roundhay Road, Leeds.
May 5th, 1913.

Sir,—I read Dr. Le Feuvre's letter *re* shingles and chicken-pox with great interest, as I have lately had a very similar case.

Some weeks ago a lady, about 40 years of age, developed a severe attack of shingles, and was nursed by her younger sister.

The patient had chicken-pox when quite young, but her sister had not. In about a fortnight the younger one was taken ill and had a sharp attack of chicken-pox, which puzzled me greatly, as I could not imagine where the infection came from. Dr. Le Feuvre's letter, however, seems to throw light on the subject.—Yours faithfully,

OTHO R. TRAVERS
(Guy's in early '70's).

171, London Road,
St. Leonards-on-Sea.
May 5th, 1913.

SIR,—In your GAZETTE of the 26th inst. I read with interest Dr. Le Feuvre's case of herpes zoster followed by varicella. In the two following cases the same sequence occurred:—

1. On the 12th September, 1908, my children's nurse began to feel severe pains in her neck, and two days later a typical cervical zoster appeared—this was seen by myself and two other doctors of medicine. The attack was severe, and the nurse who was elderly was ill for some weeks. My two sons, one aged 5 years and the other 7 years, slept in the same room as the nurse, and my three daughters came frequently into the room during the day-time. On the 28th September, just 14 days after their nurse's herpes zoster appeared, my two sons and one of my daughters developed the chicken-pox eruption; in another of my daughters the eruption occurred two days later, and my third daughter developed chicken-pox ten days after the second one. The same doctor attended my children who had attended their nurse, and the diagnosis was quite certain. As far as my wife and I knew, our children had not come in contact with anyone suffering from chicken-pox.

2. My sister-in-law informs me that many years ago, just before her confinement, one of her servants developed shingles, and they were much together as the servant suffered great pain. Ten days after her confinement my sister-in-law developed chicken-pox, having been absolutely away from anyone suffering from that affection, and she gave chicken-pox to her baby. Unless the doctor who attended her in her confinement brought the disease in his clothes, it is difficult to understand how she got it, unless it was connected with her servant's shingles.—Yours faithfully,

ROBERT S. WAINEWRIGHT,
House-Surgeon to Guy's Hospital, 1879.

Hove.

SIR,—Curiously enough the first case of Chicken-pox I have seen since reading Dr. Le Feuvre's communication in your issue of April 26th last, was preceded by Shingles in one of the parents. The case is as follows: Miss K. P., æt. 18, developed the typical lesion of Varicella, and I saw her on May 4th. I asked her parents if anyone in the house had had Shingles. Her father then told me that three weeks previously he had had an eruption on his back, which he described as a collection of "pimples" starting in the lumbar region and running downwards and forwards accompanied by itching and pain of a deep seated character. This he said tailed off as it came forward and so gradually disappeared. On examination I found marking on the skin in the left lumbar region just as he had stated, passing downward and forwards first above the crest of the ileum. I should unhesitatingly say that he had had Shingles.—Yours faithfully,

A. PERCY ALLAN.

Crogdene,
Croham Road,
South Croydon.
May 5th, 1913.

Compulsory Lectures.

DEAR SIR,—The subject of compulsory lectures has been so ably and interestingly dealt with by the editor in a recent issue, that some thoughts on the subject have occurred to the writer who begs to make a few observations.

In the first instance, it may not be uninteresting to endeavour to find the reason for men's aversion to attending these lectures. In the humble opinion of the writer the chief reason is—not that he has any particular objection to listening to a man whose knowledge on the subject on which he discourses, it is not unreasonable to suppose, exceeds that of his hearers—it is not that he has any much greater objection to spending an hour in the lecture theatre, than in any other part of the educational portion of the hospital—his chief objection to attending is that he is forced to attend.

So deep, indeed, is this aversion that cases are on record, in other hospitals than ours, of men who have been credited with having attended a full course of lectures by enriching a particular individual to the extent of half a crown. Such a procedure, for reasons into which it is not here expedient to enter, is unfortunately not possible at this hospital.

A man will perform an action or attend a ceremony the least willingly if he is forced to do so. If an individual were forced to walk a mile every day he would be a most unwilling walker, but if circumstances were altered and he were forbidden under heavy penalties to walk that mile, then would the ambulatory desires in him be strongest.

If such a state of affairs were conceivable, that lectures were debarred to all except a favoured few, and those forbidden to attend could don the cloak of invisibility, there is good reason to believe that the attendances would surpass record.

What, then, would be the result of making the lectures optional?

Men would still attend the lectures, and although the lecturer might not be favoured with a particularly

large audience, he would, nevertheless, have the satisfaction of knowing that that audience was an appreciative one since it had come willingly, and he would not have his thoughts distracted by the untimely disappearance of those gentlemen who grace the lecture theatre with their presence merely from a janitorial point of view.

The gentleman who would attend no lectures at all, to paint him in his brightest colours, is the individual who seeks consolation from his daily woes in the perusal of the numerous periodicals placed at his disposal in the club smoking-room, and who, after a somewhat protracted morning thus spent, recuperates his failing strength by the consumption of various delicacies, provided in the club-room at a small expense, before further bracing his nerves for the next day's ordeal by the observation during the afternoon of some dramatic spectacle exhibited on the stage.

What is the object of forcing such a man to a lecture? Will he attend when you get him there? Let the examining board deal with him. When he has paid the examiners several not exactly successful visits, from his point of view, the thought will probably occur to him that he might acquire knowledge from the words of wisdom of others.

But to deal with the subject more broadly, it is obvious that if any man attend a lecture against his will he will derive little benefit from that lecture, as he will not be a willing listener and will leave at the earliest opportunity.

The editor in his article quotes the following from Dr. Johnson with regard to lectures: "If your attention fail, and you miss a part of the lecture, the lecture is lost; you cannot go back as you do upon a book."

This is true, but a man cannot expect to grasp all that is said at a lecture—even if he did he would not remember the facts for any length of time. If during a lecture he picks up a few odd facts, or in attending an operation he notices merely some small point, such as a particular method of inserting a suture, he has learnt something. It is by the accumulation of small portions of knowledge at frequent intervals protracted over a course of years, and not by the acquisition of a vast amount of knowledge in a short space of time that we can hope to become competent men. The interest of a lecture depends not so much upon the subject matter as upon the man who delivers the lecture. There are some lecturers to whom men will lend willing ears, and others at whose lectures their desire would be to have no ears at all.

Therefore, if compulsory lectures there must be, and at present there seems to be no reasonable prospect of any other arrangement, then let the men who are elected to give those lectures be thoroughly competent to put their subjects to the students in as interesting and comprehensible a manner as possible.

E. R. B.

SIR,—As an old Guy's man I always look forward with pleasant anticipation to receiving the GAZETTE. There is generally something instructive contained therein, and very little controversial matter. How far this benefits or interests old Guy's is a matter of opinion, I presume.

In this number, however, there is something to say in regard to the "Passim" remarks, that is, how far "lectures" benefit or not students. Now, to my mind, this is a great and important question—because there are lecturers and lecturers, and it entirely depends upon the *lecturer* himself as regards the benefit and usefulness of them.

Some lecturers, although possessing the knowledge and who probably are very clever men, do not possess the ability to impress and convey to their audience and "hold them," so that the instruction given is lost, and becomes a waste of time to the listeners; the latter would gain more knowledge in reading.

There are others—and these are few—who possess the faculty of impressing the "objective subject" on the cerebral tissues of the listeners. These "photograph" their views, ideas, and knowledge on the grey matter as "objective," and, therefore, convey a lasting impression which all the "subjective" work—reading—could never accomplish.

Therefore, the whole question, to my mind, entirely depends upon the lecturer himself; that is, if the lecturer has that force of personality which we now and then find amongst the human race, he will by that personality so impress on the students an "objective lesson" that the student will ever retain through his life. If, on the other hand, the lecturer does not possess that personality to convey in an "objective mode" his ideas, he will not make much impression on the brain tissue of his audience, who could gain more knowledge in studying the subject in a subjective manner by means of books, etc.

I believe the above to be absolutely correct. The trouble, of course, is what you are to do under these conditions.—Yours truly, "NUERNUBARI."

Change of Address.

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(The Editor will be very glad to receive a postcard with notes of any change of address.)

Phonology.

A paper read before the Pupils' Physical Society.

By W. A. AIKIN, M.D.

The existence of a special practical science of Phonology has been called for by the desire for a more definite and uniform basis of teaching than has existed hitherto, among those engaged in training the voice, either in speech or song. It thus became necessary to promote this special branch of Physiology and to bring it into such form as might be made available to the teachers in their practical daily work. In order to accomplish this, it is found necessary to make our science extremely comprehensive; and, while basing all our conclusions upon Physical, Physiological and Psychological facts, we are obliged to go deeply into the details of speech, and phonetics, and some distance into the art of music, so as to follow up important principles as far as we can to their final application.

To-night there will not be time for me to give you more than a mere outline of my principle conclusions and how they are practically applied, and to illustrate them as simply and quickly as I can. I hope to waste as little of your time as possible in describing things with which you are already familiar—such as the normal anatomy of the respiratory and vocal organs—but to make certain that we are looking in the same direction, I must ask you to adopt a general picture of the vocal instruments and their common generator—the breath.

I should mention that in speaking of the voice it is always important to distinguish between the *point of view* whence the individual feels his own voice from *inside*, and that from which we see and hear it from *outside*. Much confusion has been wrought by neglect of this precaution.

Our picture from outside comprises:—

1. Organs of respiration = expiratory *breath force*.
2. Vocal cords = *vibrator*—sounding organ.
3. Hollows of the larynx-pharynx—mouth and nose = the *resonator* = qualifying instrument.

The act of phonation is thus briefly described. The passage of the breath in expiration is impeded by approximation of the true vocal cords. The pressure exerted upon the air in the chest causes it to escape between the elastic edges of the cords and causes them to vibrate. The rapid opening and closing of the glottis produce alternate compression and rarefaction of the air particles which give rise to waves of sound. These undulations are then modified or qualified in their passage through the resonating cavities.

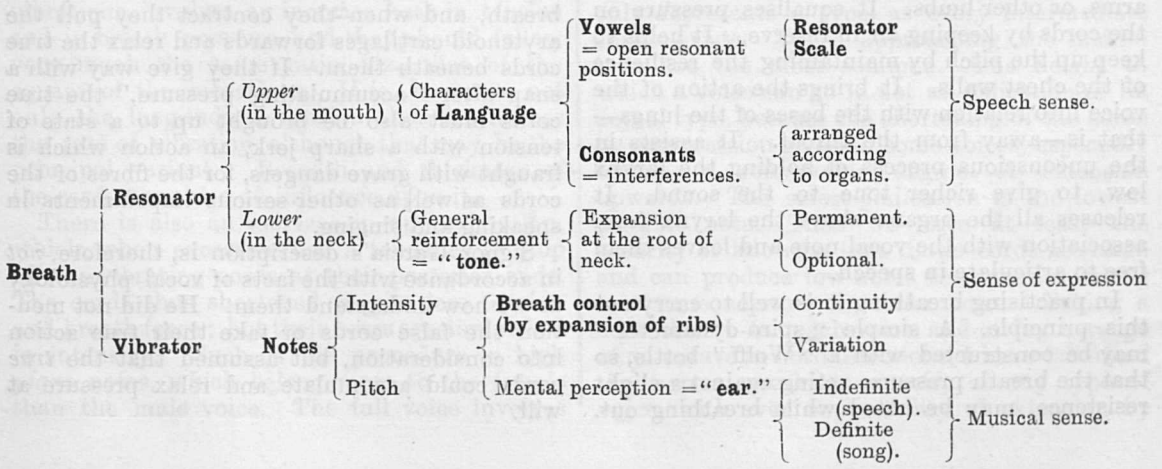
The *breath force* and the *vibrator* form a distinct sounding instrument, producing notes of varying pitch and intensity. It is governed directly by the control of breath and by mental perception or "ear."

The *resonator* is a separate qualifying instrument, giving to the vocal note its general "tone" or quality, and also the particular characters of language. "Tone" depends for the most part upon the size of the whole resonator, and particularly concerns the expansible hollow in the *neck*; and "character" depends upon the shape of the resonating hollows determined by the positions and movements of the organs of articulation in the *mouth*.

We must now consider these various components in detail.

The Breath.

The whole object of the breath in phonation is to supply a sufficient quantity, and to regulate its force. Lung capacity should be increased—for it may be necessary to take in, quickly and



noiselessly, enough to last for 20 or 30 seconds. The rhythm is the reverse of what is natural—the intake being quick and the output prolonged, and it is also irregular.

The most important factor is the control of the expiratory force—and inspiratory muscles have to be *taught* to relax gradually, and expiratory muscles to contract in due proportion. In order to secure good expansion of the bases of the lungs, the increase in circumference of the chest, in what is known as "central" breathing, is most marked at the level of the sixth intercostal space. The lower ribs on either side of the "notch" increase the lateral diameter, and the descent of the diaphragm presses forward the upper part of the abdomen within the notch. When a deep breath is so taken, avoiding all action else (viz., high costal, and low abdominal), the *forces* available for phonation are:—

1. Elasticity of lungs ... } In opposition to
2. Abdominal muscles ... } diaphragm.
3. Elasticity of lungs and chest wall ... ... } In opposition to elevators of ribs
4. Depressors of the ribs } (intercostals).

There may be several ways of controlling these forces, but the one which I consider the best is to maintain the lateral expansion of the lower ribs as long as possible. Without specially thinking about it, the necessary force is then generated by lung elasticity and by replacement of the diaphragm with gradual abdominal contraction—before the lower ribs are relaxed. What may be called the "costal air" is held in reserve for the end of the phrase, or may not be used at all, according to circumstances. The maintenance of raised lower ribs becomes a habitual position when using the voice. It is easily dissociated from all contraction or rigidity about the shoulders, neck, arms, or other limbs. It equalises pressure on the cords by keeping air in reserve. It helps to keep up the pitch by maintaining the resilience of the chest walls. It brings the action of the voice into relation with the bases of the lungs—that is—away from the throat. It assists in the unconscious process of holding the larynx low, to give richer tone to the sound. It releases all the organs above the larynx from association with the vocal note and leaves them free to articulate in speech.

In practising breathing it is well to carry out this principle. A simple "spiro-dynameter" may be constructed with a "Wolff" bottle, so that the breath pressure, acting against a slight resistence, may be noted while breathing out. The maintained elevation of the lower ribs can be felt with the hands at the same time.

I ought, perhaps, to mention that one or two medical writers have made much of a disputed rib-raising action of the diaphragm (originally attributed to Duchenne) in connection with this matter. I can only say that in watching the action I have described, under X-rays, the diaphragm moves up and down very freely; and that a large influx takes place into the bases behind the diaphragm, the liver and other organs coming well forward, while there is but very little movement of the lower abdominal wall.

The Vibrator.

We, as medical men, are deeply interested in the action of the vocal cords, because their pathology is so frequently brought to our notice. It is well to remember that their normal action is unconscious, and it is, therefore, best not to mention their existence to the lay mind for fear of inviting voluntary action where none is wanted.

The onset of a note has been the subject of much controversy, which, I regret to say, is not yet at rest.

Signor Garcia has been much honoured for the invention of the laryngoscope; but he unfortunately advocated a method of starting the vocal vibrations which is not based upon sound physiology. His "*coup de la glotte*," or shock of the glottis, was described by him as requiring that the glottis should be closed so as to accumulate air-pressure, and then opened with a snap, as by the pulling of a trigger, so that the breath should suddenly impinge upon the approximated vocal cords with a sort of stroke.

Now the *true* cords cannot accumulate pressure beneath them for their free edges are elastic and must yield immediately. It is only the false cords, or ventricular bands, which can stop the breath, and when they contract they pull the arytenoid cartilages forwards and relax the true cords beneath them. If they give way with a snap after "accumulating pressure," the true cords must also be brought up to a state of tension with a sharp jerk, an action which is fraught with grave dangers, for the fibres of the cords as well as other serious impediments in speaking and singing.

Signor Garcia's description is, therefore, *not* in accordance with the facts of vocal physiology as we now understand them. He did not mention the false cords or take their true action into consideration, but assumed that the *true* cords could accumulate and relax pressure at will.

The normal attack or onset of a note is now more correctly described as the simultaneous approximation of the true cords and application of breath-force as a single act. This is practised by putting in an H. and then gradually dropping it again. To produce a note of any definite pitch, the requisite degree of tension must be included by unconscious obedience to the mental "ear," which fixes the note before it is sounded.

During expiration some approximation of the cords takes place normally, so that, in normal phonation, all we require is that this action should be completed. We know that it is not directly voluntary, but must be dictated by the internal sense or mental perception of sound, the absence of which may be the cause of complete dumbness, or of any proportionate degree of defective intonation.

If the *pars respiratoria* of the *rima glottidis* remains open, the air-pressure naturally escapes between the arytenoids and produces a rushing noise, and the sound of the cords, if they vibrate at all, is proportionately weakened, and there is a waste of force and consequent shortness of breath.

In speaking of the vocal note, we generally assume that the *pars respiratoria* is closed, although notes of a breathy character, in which the closure is incomplete, are sometimes effectively used.

The note, once started, is maintained by continuity of the approximation of the cords and the breath-force.

Its pitch and intensity are varied by regulation of the tension of the cords and pressure of the breath. The two forces act together in close agreement. The breath remains under the control of the will; but the pitch always follows what Dr. Mott has aptly called the "tonal image" in the brain.

Rise in pitch, that is the acceleration of the vibrations, involves an increase both in tension and in breath pressure, and they should follow very much the same ratio, viz., that of the square of the vibrations. It is, however, not only the longitudinal tension that determines the rate of vibration, although that may be the principal variant. Breadth and thickness of the cords have also an influence upon it.

There is also an increase in approximation, which, when excessive, has a tendency to stop off the vibrating cords at their posterior ends. The cords thus shortened require less tension and breath force; but their notes are diminished in intensity. Such is the procedure in high *piano* notes, which belong more to the female than the male voice. The full voice involves the whole cord, and the whole of the breath-force. The influence of the thyro-arytenoid muscles in thickening the cords by their contraction has been mentioned by Dr. Mott and requires our closest consideration. My own view is that the frequency of vibration has most to do with the condition of the extreme edges of the cords, and that these muscles, although they thicken the base of the cords, in their contraction have more effect upon the pitch by relaxing the edges in opposition to the tensors or crico-thyroids.

The particular point I wish to lay stress upon is the fact that phonation should be regarded as an expiratory act with no direct consciousness of any mechanism in the larynx. After a note the vocal cords separate and go out of action, and the breath-pressure is withheld. Some escape of breath after the note is not an error, but a normal occurrence. It should be made inaudible, if possible, by controlling the breath. In considering the vocal note I must draw your attention to a difference between speech and song. In speech the vocal cords behave in a somewhat irresponsible manner, with the object in view of making words audible and their sense intelligible. But it is also their function to convey, with the full meaning of language, all that mind and emotion can express in words. This they do in a music of their own, which is the spontaneous reflection of thought, and worthy of much more æsthetic attention than is given to it. In song, on the other hand, the vocal cords have all the responsibility of a musical instrument in addition to their other functions, and have to perform what is prescribed for them by the art of the musician.

Every voice may expect a range or compass of two octaves, and voices have to be classified according to the *size* of the cords, into high, middle, and low in either sex. But each class only represents a type, as every intermediate shade exists. Those approaching the middle type are the most common. The height to which a voice can go is not an indication of its actual type, because the shortening of the cords by compression gives to some voices, especially female, a remarkable degree of extension upwards. The safest indication is the lowest possible note. Then we have at least the security of knowing that if the cords are large and can produce low notes they cannot belong to a true soprano or tenor voice. Taking a central note for each voice, and giving a range of an octave in both directions, I have tabulated the normal working capacity of any type of voice, with even a possibility of extension by

training in both directions. I have also constructed "song diagrams," showing the pitch and duration of the notes used in musical compositions, and by comparing the two, we can see at once where the work of a composition lies, and to what type of voice it is best suited.

The plan looks a little brutally scientific, and quite unlike that graceful word "tessitura," which is a vaguer artistic expression for the same thing; but its argument is unanswerable, and it serves its purpose in restraining the musical composer where the unalterable limits of the human voice are concerned.

While dealing with the vocal cords, I feel that I have taken you rather far into the recesses of the art of music; but that is only to show how far true phonological principles can be carried, not into the art itself, but into the means by which the art finds expression.

THE RESONATOR.

We have now the resonator to consider, the instrument by which sound is enriched and qualified into the characters of speech, of vital importance to those who train the voice, because its whole function depends upon *education*, and but little studied by the physiologist for this reason. Its function is not inborn, but has to be developed when we are taught to speak. In our medical studies we hardly meet with the problem of resonation, except when distorted in the case of a cleft palate.

The anatomy of the resonator is briefly:—

In the *neck*, the cavities of the pharynx and larynx; the hollow in the *mouth;* the bony cavity of the *nose* and its various sinuses.

We may say that it is composed of two principal hollows, one in the neck and one in the mouth, and an accessory hollow in the nose.

The *mouth* is made into a resonating cavity by opening the jaw, flattening the tongue, raising the soft palate, and putting forward the lips. Its internal shape can be altered by different positions of the tongue, and its front opening by different positions of the lips.

The hollow in the *neck* can be expanded by drawing the larynx downwards and forwards with the (*unconscious*) *sterno-thyroids*, and by keeping forward the base of the tongue.

The action of drawing down the larynx with the sterno-thyroids can be associated in the mind with the same sense of expansion which maintains the raised position of the lower ribs.

The idea of breath control is thus associated with permanent rich quality of sound and leaves the tongue free to articulate in the front of the mouth, and devote itself to clearness of articulation without thought of tone.

It is the forward position of the base of the tongue that produces an open throat. It is the passage down into the pharynx that is thus made open.

The nose being bony, cannot be expanded. Its use is regulated by the opening behind the soft palate.

The several functions of these components are:—

Upper: the mouth to give character to vowel-sounds and all the effects of articulate speech.

Lower: the neck to augment the general tone of the voice.

Accessory: the nose to produce the nasal character of certain sounds in speech and in a lesser degree augment the general tone.

N.B.—The *chest* is not a resonator, being entirely closed during phonation. The resilience of its walls may have some influence on pitch, and its capacity influences the continuity of breath pressure.

We can study the resonator without the use of the vocal cords, by breathing through it. The proper resonant notes belonging to the cavities will then be audible.

At the outset, we must define something, let us say the position of the vowel *AH*, so that we may know what we are investigating. The unfortunate disagreement among physiologists on this point is, no doubt, due to the neglect of this precaution.

The jaw open—about one inch between teeth; tongue flat and forward against lower teeth; lips at rest; palate raised enough to exclude predominance of nasal resonance (not directly conscious); neck straight; sense of expansion: larynx drawn down by sterno-thyroids (unconscious); chest expanded.

This represents a fully expanded resonator in the position for AH.

By breathing through this position with a little care we can determine the resonant pitch of the resonating cavities. This naturally varies according to size among individuals and the sexes, and is variable by each individual according to the power of expansion.

In my own case C″ = 526 is heard when I take the trouble to expand.

There is a natural constriction behind the tongue. Below that point the pharynx expands especially in its antero-posterior diameter—so that there are distinctly two chambers and they are set at right angles to one another.

By passing a C″ tuning fork down to the constriction there is a strong reinforcement of the sound similar to that at the lips, which shows that we are dealing with a double resonating

system with a "node" in the throat. The whole subject of multiple resonation has been but imperfectly investigated; I am inclined to believe that the resonant pitch in the neck may be regarded as C″ and that a resonant note an octave higher C′″ is very readily heard in the mouth. (I shall return to this point when I come to the full vocal sound.)

When the position of AH is once established there are two ways of changing the shape of the cavity of the mouth to make other vowels.

1. By changes of the opening of the lips for OH and OO.

2. By changes of the position of the tongue for EH and EE.

Thus from AH are differentiated the four other primitive vowel sounds which occur practically in all languages:

AH < EH – EE (tongue).
AH < OH – OO (lips).

The effect of these changes upon the resonant pitch of the cavities has enabled me to construct the system of vowel positions known as the "Resonator Scale." Starting with the resonance of AH, the extreme rounding of the lips for OO lowers the pitch a fifth. The several forms of O – OH – AW – $\breve{O}$ fall then upon the intervening notes.

In the same way the extreme forward position of the tongue in EE gives us a small cavity in front with a pitch an octave above AH and a large cavity below the tongue with a pitch a fifth lower than AH. Between these two vowels the whole series of tongue positions are established approximately upon the notes of the scale, according to their resonant pitches as we hear in the English words: Mark, much, mirth, man, men, may, miss, meet.

In the lower group, AH – OO, the two chambers—neck and mouth—are evenly balanced; but in the upper group, AH – EE, the diminution of the front cavity produces a corresponding enlargement of the lower one, and we have two scales going in contrary directions in the upper half of the arrangement. The positions are marked I. to XII. for reference.

It is interesting to note that the first advance of the tongue between V. and VI. merely opens the throat and raises the pitch of both cavities, but in VII. the disparity begins.

RESONATOR SCALE OF WHISPERED VOWELS.

Single *vowel sounds.*

	I (I*)	II	III	IV	V	VI	VII	VIII	IX	X	XI	XII
Average (Women) ...	a′b (a)	b′b	c″	d″	e″b	f″	g″ / eb″	ab″ / d″	bb″ / db″	c′″ / c″	d′″ / bb′	eb′″ / ab′
(Men) ...	f′ (f′shp.)	g′	a′	b′	c″	d″	e″ / c″	f″ / b′	g″ / bb″	a″ / a′	b″ / g′	c′″ / f′
Sound ...	o͡o (oo)	oh	aw	o͝	ah	a͡ u͡ &c.	e͡r	a͞	e͝	eh	i͝	ee
Example ...	fool (foot)	foe	fort	fox	far	fun	fern	fat	fed	fame	fit	feet

Compound *vowel sounds.*

	XI—I	VI—XI	VI—I	III—XI	XI—VII	VIII*-VI	I*—VII	XI—I*—VII	VI—I*—VII	VI–XI–VII
Sound ...	u͡ i͡—oo	i͡ a͡—i͝	a—oo	a͝w—i͝	i͝—e͝r	a͞—e͝r	oo-e͝r	i͝—oo—e͝r	a͝—oo—e͝r	a͝—i͝—e͝r
Example ...	fume few	find	found	foil	fear	fair	poor	pure	power	fire

N.B.—All vowels require an open jaw and a forward tongue. The lips come more and more forward from V to I, but remain at rest from V to XII.

The relations of the two cavities in EH $\frac{1—2}{\text{(an octave)}}$ and EE $\frac{1—3}{\text{(a twelfth)}}$ point to a natural selection accounting for the use of these sounds in all languages. They are the only possible absolute concords in the proportional division of the resonator.

This part of the subject is so full of detail that it takes too long to go deeply into it.

The Resonator Scale can be made the basis of teaching, and is the nearest approach we possess to a phonological *standard of pronunciation*. Every individual can vary the resonant quality by taking trouble to expand the resonator when full rich tone is required, as is practically the rule in singing and public speaking, or else by taking no trouble at all, as in a light conversational voice when the mouth, and that often hardly open, is acting alone. The resonant qualities of the voice, both as regards pronunciation and tone, can be cultivated without reference to the vocal notes, by carefully watching the positions and movements of the mouth, and the behaviour of their resonant characteristics, and by acquiring deep resonation in the neck, and a suitable admixture of scarcely perceptible resonance in the nose. The *consonants* are here classified according to the organs that produce them, and to the character of their sounds. It is nearly the same as that of other writers, except that I do not call T and D "dental." They can be pronounced quite well without teeth, but require the tip of the tongue against the hard palate as far forward as possible.

The acoustical problems involved in the introduction of the vocal note, varying in pitch to the extent of two octaves or more, into a compound variable resonator, cannot be very simple. But they are not nearly so inexplicable as they might seem at first. The vocal note is strong and fixes its own pitch, while the *resonator* is comparatively weak and responds to harmonics of the vocal note, producing the special characters of language by changes in the mouth, and adjusting the tone of the whole sound by slight changes in the neck. The resonances in the neck are the lowest, but are yet mostly above the compass of a man's voice, and only come into contact with the primary tones of the upper notes of a woman's voice, which are generally most beautiful in consequence.

The actual mouth resonances upon which the vowel characters depend are so much higher that they have no difficulty in finding suitable harmonics to respond to.

There is a certain amount of elasticity about resonant reinforcement which spreads itself over a semi-tone or two, and this is extended by some degree of adaptation of the resonating hollows—so that in a rising scale the range of one harmonic can be stretched, as it were, until a lower harmonic is ready to come and take its place.

At each harmonic change there is always an alternative; and since the sound of the voice is always improved by expansion in the neck, the rule is to expand towards the lowest harmonic possible, while keeping the high resonance in the front of the mouth forward, open and unchanged. The old Italian masters probably meant this when they told their pupils when

TABLE OF CONSONANTS.

	Incomplete Closures.				Complete Closures.		
	Aspirates.	Continuants (sounding).			Explosives.		
		Buccal.	Nasal.	Roll.	Unvoiced.	Voiced.	
1. Larynx	H	—	—	—	—	—	Jaw
2. Tongue (body) & hard palate (back)	—	—	NG	—	K	G	well
3. Tongue (tip) and hard palate (front)	—	L	N	R	T	D	open.
4. Lips	—	—	M	—	P	B	Jaw
5. Lower lip and upper teeth	F	V	—	—	—	—	partly
6. Tip of tongue and upper teeth ...	TH	TH	—	—	—	—	open.
7. Teeth	S	Z	—	—	—	—	Jaw
8. ,, (with lips)	SH	J (soft)	—	—	—	—	closed.
9. ,, (with lips and tongue) ...	—	—	—	—	CH=TSH	JG=DJ	

N.B.—When a consonant precedes a vowel there is an opening movement to the vowel position, and a closing movement when a consonant follows a vowel. The jaw takes part in the movement only to a certain extent, viz.: fully in 7, 8 and 9, less in 4, 5 and 6, and scarcely at all in 1, 2 and 3.

they had to sing high notes, to imagine they were singing an octave lower.

It is fairly clear, on the table of harmonic reinforcements which I have worked out, how every vowel is characterised by something approaching a definite composition. But we must not be misled, as some of the physicists were (including, I regret to say, the great Helmholtz), into the belief that the character of a vowel depends upon any particular note or any particular harmonic. These both vary sufficiently to dispel that idea.

We have therefore to conclude that it is the shape of the resonant vibration that enables the ear to distinguish one vowel from another, and not in any way its frequency. And this holds good in practice, for a small child can talk the same language as a giant, and with exactly the same distinct characters, but with absolutely different sounds.

We are now in a position to sum up the entire act of phonation in the following description :—Associated with the act of breathing out, vocal vibrations are awakened in obedience to a mental auditory sense. In passing through the resonator, the lower harmonics of the vocal vibrations are reinforced in the neck and behind the tongue, to augment the general "tone" of the voice; and higher harmonics are reinforced in the front of the mouth to produce the characteristics of vowel sounds.

The whole quality or "tone" of the voice is due to reinforcements by all the chambers of the resonator—neck, nose and mouth together; but it is the part regulated by the organs of articulation, *i.e.*, the front of the mouth, which gives the finishing touch before it leaves the lips, by impressing upon the sound the subtle characteristics of speech. When the auditory sense expresses itself in terms of music—a highly complex sound organisation—speech is converted into song.

Out of these conclusions naturally arises the practical direction of voice development on the following lines.

Deep breathing with the bases of the lungs.

Control of breath force by holding and regulating the lower ribs.

Vocal note part of an expiratory act—for which breath force is always responsible in conjunction with the mental perception or ear—the musical sense—and no local consciousness of larynx.

Tone or sonority by expansion in the neck, associated with the sensation of richness of sound and not with definite muscular action.

Characters of speech, loose and free, articulation in the fore-front of the mouth, good open forward positions of vowels, and free movements for consonants. Open throat, forward tongue, loose open jaw, loose uncontracted lips, facial and bodily ease. The *words* are literally above or in front of the tone, and must never lose their character for purposes of sonority.

The one thing that never rests is the breath control. All the fatigue should be borne by the lower ribs.

It should be remembered that the functions of the organs can always be improved by exercising them on proper lines, and most bad habits have only to be recognised to be overcome.

Cases of aphonia which come under your notice may be from many causes, but when there is no mechanical interference with the approximation of the cords, I have repeatedly found that failure to approximate is often due to the absence of the mental association of phonation with breathing out. A fictitious method of initiating sound, as in the shock of the glottis, is easily interfered with by a slight laryngitis, or even slight throat fatigue. The deep association of breathing with sound, involving no action above the cords, is not so easily affected. Many cases of stammering illustrate this principle, and betray either defects of breathing or failure to associate vocal sounds with the act of expiration.

I hope I have been able to show you how wide is the field traversed by the Science of Phonology. It is thickly set with endless detail which I have been obliged to leave untouched in this all too brief space of time. I must be satisfied if I have succeeded in explaining the definite way in which scientific research can influence the practice of voice-training for the great benefit of all concerned, and especially of those who have to listen.

That the cultivation of the voice, and especially of the speech organs should be left to chance, or the guess-work of the charlatan, is not a credit to our education. I am glad to think that things are improving in this respect. I therefore feel it doubly my duty, as well as my pleasure, to submit all that I have to say on behalf of Phonology to the sternest criticism of those whose scientific judgment I know to be based upon that appreciation of physiological truth which the sight of these walls brings so strongly to my own memory.

The Treatment of Pelvic Inflammation.

BY HAROLD CHAPPLE, M.C.

To determine the wisest course to adopt in the treatment of a case of pelvic inflammation is often a matter of great difficulty. Speaking generally, there are two methods available—the operative and the palliative, and of these the operative, although it has such strong advocates, presents such grave objections, especially when one considers that the condition whose treatment is under discussion occurs, as a rule, in young women, that its adoption is not by any means attractive, and any method that will avoid the sacrifice of the female genital organs must of necessity be considered as being much the more desirable.

The inflammatory condition is, in the vast majority of cases, due to the presence of micro-organisms that have been introduced by some means from below. In a large number of swabs that I have taken in the wards and at Out-Patients a very remarkable variety of organisms has been found, and in chronic cases in which the history has pointed strongly to the causative organism being the gonococcus, we have frequently failed to detect its presence either in the vaginal swabs or those taken from the cervix and urethra.

It is now fairly generally accepted that an increased blood supply to a focus of inflammation causes the liberation into the general circulation of an increased quantity of toxins. If, then, we could produce a congestion definitely localised to the inflammatory area in the pelvis, we should be able to liberate an amount of the products of the actual offending organisms, and so bring about an auto-inoculation. The difficulty of isolating the offending organisms would thus be overcome.

With a view to investigating the possibility of this during the last few months, several such cases have been admitted into Queen Ward, and the observations I have been able to make and the results obtained are, I venture to think, sufficiently interesting to warrant their being placed on record for consideration and criticism.

Local congestion in the pelvis is now produced by the heat emanated from a series of electric lamps suspended in a concave, crescent-shaped metallic frame, so arranged that its heat is reflected directly on to the patient's pelvis. The thighs and upper abdomen are suitably shielded with an asbestos covering, and the rest of the patient is left bare or covered only with a thin sheet. At first the patient's body was kept entirely covered, but it was found that this resulted in a rise of two or three degrees in the general body temperature and a feeling of considerable exhaustion at the end of half an hour's exposure to a temperature of 180° F. And under these conditions a maximum thermometer placed in the vagina failed to show any corresponding rise of temperature. This was of comsiderable interest in showing how very little local effect was to be expected from the application of hot fomentations to the abdomen, hip baths, or the use of hot vaginal douches.

This difficulty has been met by placing in the vagina a suitable sized Fergusson's speculum whose inner end lies in the posterior fornix, and so almost in contact with the inflammatory mass, and whose outer end opens directly into the bath and is exposed to the direct heat of the lamps. By this means it has been found possible to expose the patient's pelvis to a heat of 180° to 190° F., and a maximum thermometer placed in the speculum recorded up to 120° F. When directly in contact with mucous membrane in the posterior fornix it registered up to 103° F., whereas the mouth temperature was found to be 99°F.

At first the maximum temperature of the bath to which a patient could be exposed was about 140°F., and its duration 15 to 20 minutes. This process was usually followed by a sense of depression, and the patient did not feel so well for the next twenty-four hours. At the same time the pelvic pain was considerably relieved. After a few applications the bath temperature can be raised to 180° or 190° and its duration lengthened to half an hour or more. Soon the patient is able to stand this easily, and it is not followed by that feeling of malaise which attended the first exposure. Should this feeling not disappear, we have found it wisest to give the baths every two or three days instead of daily, and we explain it by the fact that we are giving the patient too large a dose of toxins. This effect was most marked in one of the patients who improved rapidly when we gave the bath every third day instead of daily.

The effect on the pelvic pain has been most marked. Indeed, it has been one of our greatest difficulties, in that the patient relieved of her pain is not easily convinced of the necessity of remaining any longer under observation despite an assurance of the presence of the inflammatory masses in her pelvis. From the cases treated I have selected two, the former of which represents the effect on a chronic case, and the latter an acute one. We have had these two patients up into the ward to be seen again on April 30th, so that the effect produced has so far been a lasting one.

Case 1.—Lizzie B., aged 30, married 6½ years, came up for pain in the left iliac region, sterility, and a persistent vaginal discharge. The abdominal pain had commenced three years ago, and at that time she noticed a thick vaginal discharge. From that time onwards this pain has been almost continually present. It was made much worse by any exercise. The periods were always regular, but lasted five to seven days, and the loss was considerable. The onset of the period was attended with much pain. Dyspareunia had lately become very marked. For the

last two years she had felt weak and unfit. She had been treated without benefit for several months with hot vaginal douches, hot hip baths, and tonics.

On admission she was found to have a copious vaginal discharge, the uterus was retroverted and fixed, and any attempt to move it was associated with sufficient pain to cause the patient to exclaim. Posterior to the uterus were two definite fixed tender masses, and a diagnosis of bilateral chronic salpingitis was made. On inquiry there was evidence pointing distinctly to a gonorrhœal infection, but we were unable to detect the gonococcus. She was treated with the applications of heat as described. She was in hospital for six weeks, and daily applications were made except during the menstrual period. At first they were followed by marked malaise, but this passed off after a few applications, and the pain rapidly disappeared.

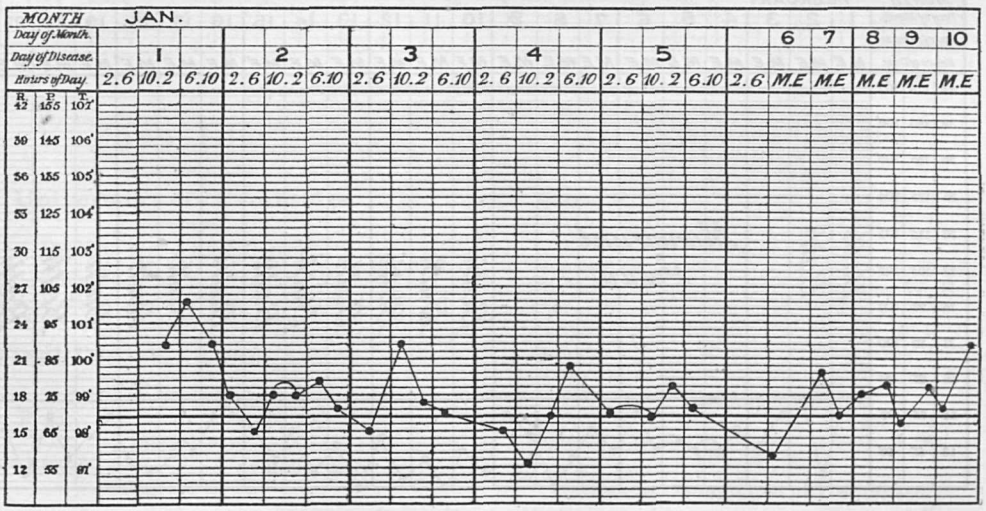
She was seen again on April 30th in Queen, having been home for three months. The discharge is now only present two or three times during the month, and is then slight. She has had no pain whatever. The dyspareunia has disappeared completely. The period lasts now three days, and the loss is much decreased. In general health "she has not felt so well for ten years," and has put on weight. On vaginal examination the uterus is readily movable, and this movement is not associated with pain unless an extensive movement is attempted. In the place of the inflammatory masses there is a very much smaller mass attached to the back of the uterus which is not tender on manipulation.

Case 2.—Emma T., a married woman, aged 31. She had a child nine years previously. She had begun to feel out of sorts a year after that event, and had been troubled with a persistent vaginal discharge. She had been treated at a London hospital for nine months with douches and local applications, but with no benefit. Then she had gone to another hospital, and had attended the Out-Patients of that institution for another two years, and had been treated with douches and applications of copper salts, etc. Her condition did not improve. She had also been vaccinated for five months for her trouble without any definite benefit. There was a continuous vaginal discharge, no menorrhagia, considerable dyspareunia, and sterility. She was admitted on the 1st of January, as an "acute abdomen," with the story that two months before she had had a bad attack of abdominal pain with a definite vaginal discharge, but although the pain had not entirely disappeared it had not been so acute. On January 1st she had had a sudden attack of pain in the left iliac fossa associated with vomiting. The bowels were relaxed. The condition became worse, and the pain increased and crossed the middle line to the right side. Next morning she was worse, and was sent up to hospital and admitted.

On admission, temperature 100—4°; pulse 104; furred tongue; abdomen not much distended, but tympanitic. No definite rigidity, but diffuse tenderness most marked in the left iliac fossa.

Vaginal examination was accompanied by marked tenderness in posterior fornix, and any attempt to move the uterus was associated with acute pain and caused her to exclaim. No definite lump was made out in the fornices. A somewhat profuse vaginal discharge was present. A diagnosis of acute bilateral salpingitis was made with some pelvic peritonitis, and this was confirmed by the formation about a week later of two very definite tender lumps, about the size of a small orange in the posterior lateral fornices.

The daily heat applications were commenced on January 16th, and their effect was definitely shown in the accompanying temperature chart. After the first application the patient fell ill, but this malaise disappeared after four applications, and the abdo-

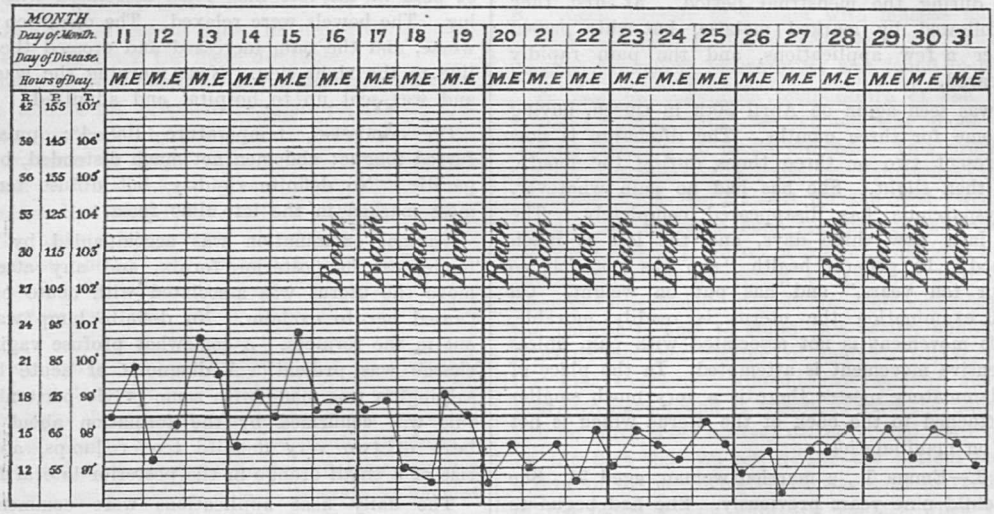


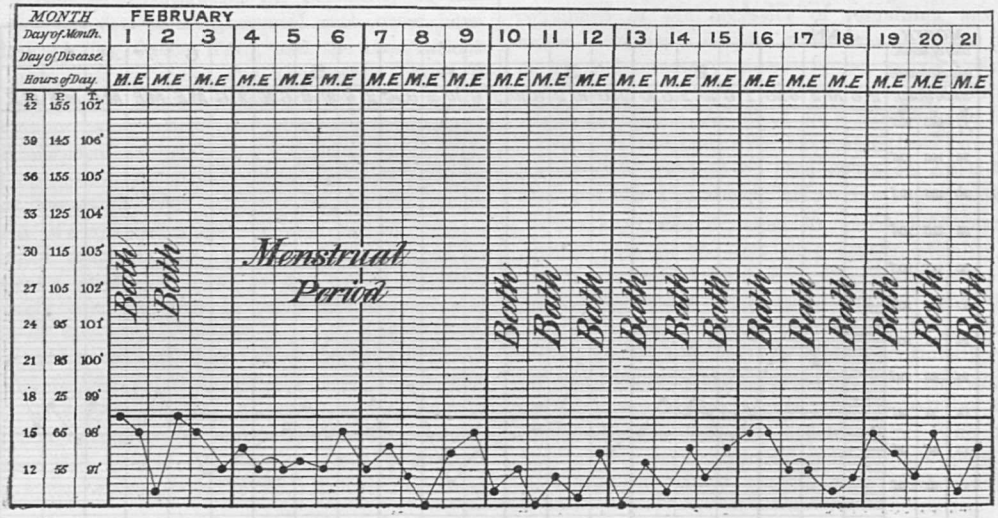
minal pain was relieved very quickly. After the fourth application the temperature fell to normal, and did not rise above it again.

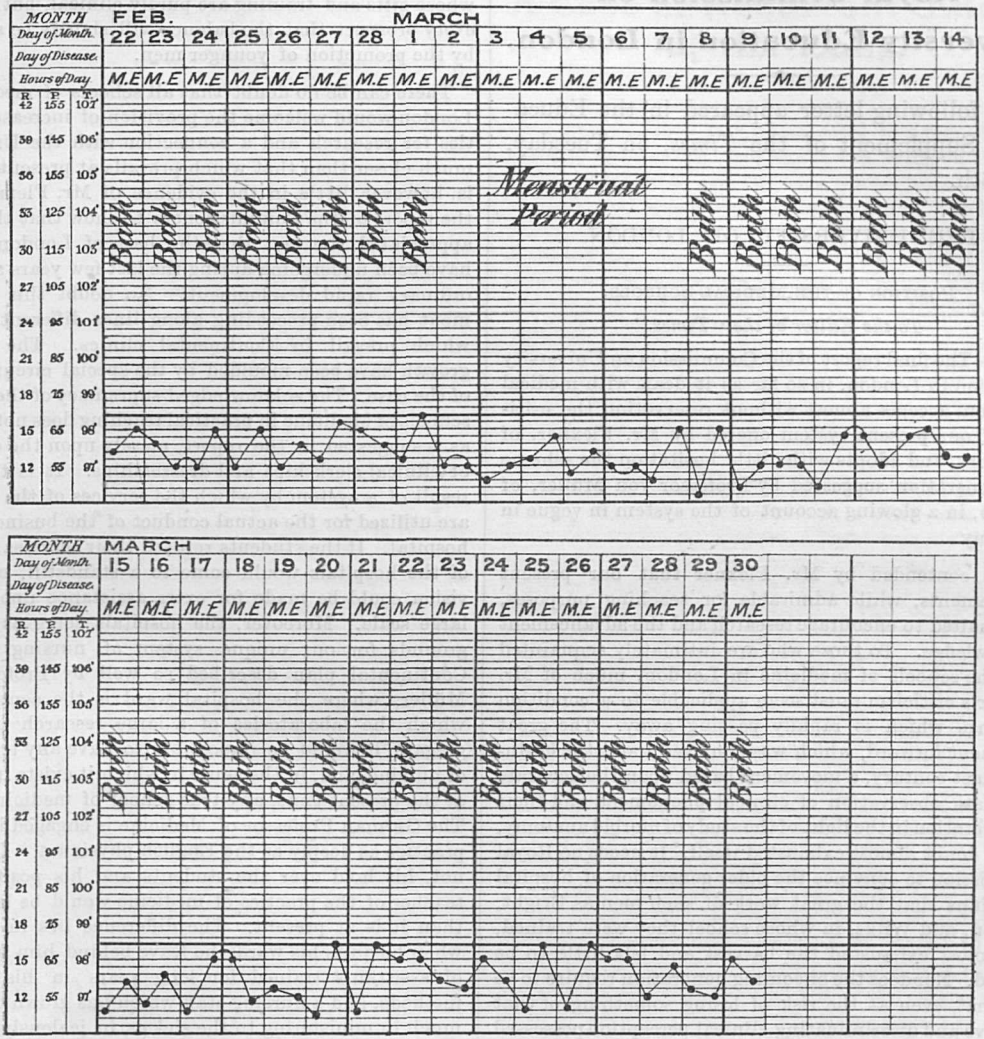
She was seen again on April 30th in Queen, and looked and felt in excellent health. She had had no pain since being discharged from hospital. The vaginal discharge had gone. The uterus was found to be movable without any marked pain, and the pelvic masses were much reduced in size, and replaced by fibrous tissue, which was not tender on manipulation and was definitely movable.

Whether the explanation of these phenomena is the correct one or not, the clinical fact remains that in these patients the tender pelvic masses have disappeared, and their sites are now marked by fibrous thickening which is not tender. The mobility of the uterus has been regained, dyspareunia is no longer complained of, the chronic vaginal discharge has disappeared, and the patient's ovaries are left intact.

It has been urged against this treatment that the Fallopian tubes are no longer patent with fimbriated extremities, and so are diseased organs. This is probably true, but it is more than compensated for by the fact that the patient's ovaries are left *in situ*.







Pass List.

University of Cambridge.

SECOND M.B. EXAMINATION.

Part II.—Pharmacology and General Pathology.

Boswell, P. R. | Starling, E. C. W.

Final Conjoint Examination.

Medicine and Surgery.

*Berry, P. H. | Smith, A. J. E.

Medicine only.

Barrow-Clough, J. R. | Erulkar, A. S.

*Mahon, E. M.

Medicine and Midwifery.

Moberly, A. V.

Surgery and Midwifery.

Evans, H. W. | Scott, E. D.

Martin, E. G. | Taylor, E. S.

Surgery only.

*Bennett, R. S. de C. | *Jones, G. B. H.

*Blake, E. W. | *Ogilvie, W. H.

*Collar, F. | Pedley, C. F.

*D'Arifat, A. C. L. | Penny, C. H. G.

Gould, C. H. | *Pickering, D. V.

Hancock, A. C. | Whitworth, W. C.

Midwifery only.

Davies, W. L. G. | Lauder, J. L.

Jones, D. W. | Lucas, R. H.

*Poyser, R. C.

*Denotes completion of Examination.

Royal Commission on University Education in London.

The following letter appeared in the Educational Supplement of the *Times*, on Tuesday, May 6th.

THE UNIVERSITY OF LONDON.

POSITION OF THE MEDICAL SCHOOLS.

To the Editor of the "Times."

SIR,—The final report of the Commission on University Education in London, in so far as it deals with medical education, accepts almost without reservation the criticism of our present system offered by Mr. Flexner, of New York, and adopts with little hesitation the scheme for regeneration suggested by Professor von Müller, of Munich, in a glowing account of the system in vogue in Germany.

It is contended by Mr. Flexner that our present arrangements, while admirable for teaching purposes, are ill suited to encourage research and the advancement of knowledge. To those who are intimately acquainted with the schools of medicine in London, much of Mr. Flexner's criticism must seem applicable to a condition of things which is rapidly passing away. The great movement forward, which was achieved about the beginning of last century, a movement based upon the accurate systematic observation of clinical phenomena and their interpretation in the light of the study of morbid anatomy, has no doubt almost exhausted itself. It needs no Royal Commission to convince the older generation of hospital physicians that the great work of such men as Bright, Addison, and Wilks, in whose school they were trained, has almost exhausted the harvest and left little to be gleaned. Nor does the oncoming generation require to be told that, even at the risk of losing something of that sensitive and discriminating clinical perception possessed by their predecessors in perfection, their own work and training must in the future lie largely in the study of disease in the laboratory. For the past ten years or more such a change has been taking place in the work of the younger men. At Guy's Hospital, for example, since 1897 upwards of £100,000 has been spent in the provision of laboratories for the work of teaching and research, an expense which has been borne entirely by the school without contribution of any sort from the funds of the hospital. At the present time, besides members of the hospital staff, there are twenty-five investigators at work, the conditions of whose appointment preclude their engaging in private practice, and who are in receipt of salaries varying from £600 for the heads of departments to £150 for assistants—salaries not indeed sufficient, yet comparing not unfavourably with the remuneration of similar posts in Germany. No doubt in all schools of medicine there is still an over-representation of those whose gifts and training are purely clinical, but there is every prospect that the balance will shortly be adjusted by the promotion of younger men.

There can be no doubt that all schools of medicine in London would welcome the provision of increased facilities for research and a connection with the University much closer than that which prevails at present. There is, however, little in the evidence of Mr. Flexner or in the report of the Commissioners to show that they have appreciated the fact that the best of London schools have been undergoing during the last few years an extraordinary rapid development. No doubt this development has been proceeding along lines different to those which prevail in Continental clinics. The lines of growth have been moulded by the special circumstances of the case. The acknowledged supremacy of the London schools of Medicine in practical teaching does not depend, as is suggested in the report, merely upon the existence of clinical clerkships and dresserships. It is the direct result of a system by which the services of the students are utilized for the actual conduct of the business of the hospital. If the students refused their services the work of the hospitals would come to a standstill, until provision could be made for extra assistance upon a very large scale. Moreover, the hospitals serve as training grounds for our unique system of nursing. In the Continental plan described so well by Professor von Müller, where the hospital ward is the centre round which the laboratories of a large research unit congregate, it would be impossible to have any true school of nursing, and, in the sense in which it exists in London at the present time, any true school of medicine at all. The German Professor of Medicine is engaged in private practice as deeply as the English physician. If he were not, his hold over the students and his position as a teacher of the practice of medicine would be less secure than it is at present. The difference lies in this that when he quits his wards he leave behind him a number of assistants trained for long years in his peculiar methods, and a nursing staff which has grown old not so much in ministering to the sick as in jealously guarding the routine of his research. The constant change of house officers, the long succession of nurses and students in training would invariably upset the complicated mechanism of the large research unit.

Secondly, the conditions under which research is possible in London are determined by the accident that the hospitals are supported by voluntary contributions, a system which is our pride and the wonder of all other countries. The subscriber to the hospital has not yet learned to regard the provision of a clinical laboratory as something as essential to the work of a physician as an operating theatre to a surgeon. It follows that, while in all hospitals surgery is generously provided for, the more complex investigation of medical cases must be carried on, not in laboratories communicating with the wards and supported by the

hospital, but in separate institutes, each dealing with a separate branch of science, often built and equipped entirely at the expense of the school. It is this unavoidable separation of laboratory work from the hospital buildings which is apt to give the visitor to our schools a false impression of the actual extent of the provision for research.

To those who have the welfare of medical education at heart the report of the Commissioners must be of the most intense interest. Careful and unbiased inquiry has brought to light many deficiencies and not a few faults in our present system, which are not solely dependent on meagre endowments, embarrassed finances, and the large number of competing schools, some of which certainly are on the verge of bankruptcy. In its final recommendation, although actuated by the best of all motives—a desire to increase the volume of original investigation carried on in the schools of the University—the Commissioners stand upon very dangerous ground. They recommend nothing short of the transportation *en bloc* of the machinery of a large research unit upon the German plan and the attempt to acclimatize it in the atmosphere of an English voluntary hospital. Such an attempt would entail the most serious risk to our own native institutions, in some of which we stand supreme. Our schools of nursing, our whole system of instruction of medical students in the practical details of their profession, and our system of voluntarily-supported hospitals, are all disturbing factors in a scheme borrowed ready-made from our neighbours. The adoption of the alternative design—the retention of a system of small clinical units, working, so far as research is concerned, in close communication with the various departments of pure science with which the school must be equipped—has been forced upon us by the necessity of continuing those institutions in which we legitimately take pride. That the output of research has been smaller in the past than we should wish is due only to embarrassed finances and the length of the tenure of their appointments by a school of physicians, whose merits, undoubtedly great though they are, have not, as a rule, tended towards modern scientific research. The larger and better-equipped schools in London have already gone a considerable way towards the solution of the difficulty, and are advancing with rapidly-increasing momentum along lines which have been devised to interfere as little as possible with the growth and development of our native and peculiar institutions.

I may add that in what I have said I am expressing my own views and have in no way consulted my colleagues in the school.

H. CHARLES CAMERON,
Dean of the Medical School.
Guy's Hospital.

Medical Schools,
Guy's Hospital, S.E.

A Case of Recurrent Œdema of the Lung.

The following notes may prove of some interest—At 11 p.m. on April 15th last I was called to a man 39 years old, said to be dying. He was in bed, lying on the right side, with his head over the edge, whilst from his mouth escaped small quantities of a frothy fluid. The face was pallid, covered with sweat, the ears and nose somewhat cyanosed, the cheeks showing marked venules. Respiration was 36 to the minute, and the pulse—a small one felt through a thickened radial artery—108. Temperature sub-normal.

A brief examination showed loud moist râles over the whole of the back and as much of the front of the lungs as could be reached. The cardiac impulse could not be felt owing to the laboured respirations, and no cardiac sounds were audible.

The fluid which was being pumped out of the mouth at each expiration measured over a pint—was albuminous and tinged with blood. There was no cough or vomiting. The patient, though emptying the bladder before retiring to bed at 9.30, had passed a considerable quantity of urine involuntarily. The bowel was unaffected.

Stimulants helped towards a more comfortable condition by 11.35 p.m., and the patient was able to talk a little, remarking that the pain over the front of the chest was better. He coughed for the first time—expectorating a little frothy fluid. Within the next five minutes there was a relapse—more fluid escaping, and the patient gasping out that he was dying. By midnight he was better, and able to recline on three pillows. His colour had returned, and he appeared comparatively well.

The history of the attack is, that shortly after 9.30 p.m. he had gone to bed, after a hard day's work, painting—a calling he has followed for ten years. About 10 o'clock the breathing became short, accompanied by a feeling of suffocation, and this was followed by the escape of fluid from the month. There is a previous history of similar attacks. In July, 1911, immediately after coitus, he brought up "something like thick phlegm," and felt ill. This was followed at intervals, on four or five occasions, up to the beginning of this year, and always after connection.

On January 4th last, the patient was seized, in a similar manner to that described above, at a meeting, and was thought to have a pleural effusion escaping through the lung by the medical man who was called. The last two attacks have been much more severe than any previously. The man is an abstainer, and leads a quiet life. He has been married nine years and is the father of three children. He has had several attacks of influenza followed by great weakness, and is subject to bilious attacks. There is no outward evidence of plumbism.

On the 16th, the condition was as usual. Lung sounds normal—the heart action quiet, but the organ enlarged

—the apex half-inch outside the nipple line in the fifth interspace, no murmurs. The urine was moderately acid—spec. grav. 10–20—no albumen, in a 12-hour specimen following the attack. I regard the case as one of recurring œdema of the lungs following failure of the left heart, and Dr. Herbert French, to whom I mentioned the case, suggests the possibility of the heart condition being due to lead, derived from the painting.

The Clinical Research Association's report on the fluid is as follows :—

"The fluid is alkaline in reaction, has a specific gravity of 10–18, and an albumen content of 2·6 % (aufrecht). The centrifugalised deposit is considerable in amount, and consists of numerous blood discs, small numbers of leucocytes, fair numbers of pigmented alveola cells, some columna epithelium, probably of bronchial type, and a small number of squames ; some fibrinous clot is present, but lung tissue or cell cellular postules suggestive of new growth formation are not seen."

"The specimen is hardly purulent in character, and tubercle bacilli are not detected, but fair numbers of micrococci are found." H. S. BROWN.

May 4th, 1913.

Guy's Hospital University of London Club.

The Annual Dinner of the Club was held on Friday, May 2nd, at 7.30 p.m., at the Criterion Restaurant. Mr. F. F. Burghard, the President of the Club, was in the Chair, and twenty-one members and guests were present. After the loyal toasts had been drunk, Mr. W. Sampson-Handley proposed the Club, and the President replied. The Dinner was very enjoyable, but general disappointment was expressed at the very poor attendance.

Papers by Guy's Men.

H. Charles Cameron, M.D., M.R.C.P. : The Uses and Abuses of Proprietary Foods in Infant Feeding.—*British Medical Journal*, April 26th, 1913.

R. G. Chase, M.B., B.C. Cantab. : A Case of Chronic Plumbism in which Multiple Aneurysms occurred.—*British Medical Journal*, April 26th, 1913.

H. T. Depree, M.B., B.C. Cantab. : Adrenalin in Chloroform Anæsthesia.—*British Medical Journal*, April 26th, 1913.

Kenelm Digby, M.B., B.S., F.R.C.S. : Testing of Symptoms.—*Practitioner*, May, 1913.

J. M. Fortescue-Brickdale, M.A., M.D. Oxon. : Some Points in the Causation and Treatment of Gastric Hyperacidity.—*Clinical Journal*, May 7th, 1913.

Sir James F. Goodhart, Bart., LL.D., M.D., F.R.C.P. : Peripheral Stasis.—*Practitioner*, May, 1913.

F. W. Langridge, M.R.C.S., L.R.C.P. : Some Reflections Suggested by a Bladder Case.—*Clinical Journal*, May 7th, 1913.

W. Sampson-Handley, M.S., F.R.C.S., and another : Cheilotomy : A Function—restoring Operation in Crippling Traumatic Arthritis of the Hip-joint.—*British Medical Journal*, May 3rd, 1913.

W. H. Maxwell Telling, M.D., B.S. Lond., M.R.C.P. Lond. : Some Remarks on the Diagnosis of Primary Intra-thoracic Malignant Disease.—*Clinical Journal*, May 7th, 1913.

A. H. Tubby, M.S., F.R.C.S. : A Lecture on some obscure Affections of the Foot.—*Clinical Journal*, April 23rd, 1913.

C. J. Whitby, M.D. Cantab. : Prevention versus Cure in Modern Practice.—*British Medical Journal*, April 26th, 1913.

Guy's '89 Club.

The eighteenth annual meeting and dinner of Guy's '89 Club will take place on Wednesday, 14th May, at the Hotel Cecil, Major H. Hewetson, R.A.M.C., in the chair, About twenty members have intimated their intention of being present, and the Hon. Secretary, H. J. Spon, will be glad to hear, not later than the 12th inst., from those others who will be able to attend.

Births.

EYRE.—On April 29th, 1913, at The Warren, Tulse Hill, S.W., to Dr. and Mrs. John Eyre, a daughter.

LEEMING.—On April 22nd, 1913, at The Friars, Sudbury, to Dr. & Mrs. Leeming, a son.

Marriages.

HOBSON—COLLINGWOOD.—On April 30th, at S. Oswald's Church, Ravenstonedale, Westmorland, by the Rev. E. A. McComas, assisted by the Rev. E. M. Tweed and the Rev. T. S. Boulton, Vicar, Alfred Allen, son of the late Alfred Hobson, of Spalding, Lincolnshire, to Mary Ann Denton, daughter of the late Dr. William Cuthbert Collingwood, of Sebergham, Cumberland.

POLLITT—POTTER.—On April 29th, 1913, at S. George's, Hanover Square, W., by the Lord Bishop of London, Gerald Paton Pollitt, L.D.S. Eng., D.D.S. Penn., to Dora Hilda Potter, younger daughter of Henry Percy Potter, M.D. Durh., F.R.C.S., D.P.H. Camb., Medical Superintendent, Kensington Infirmary.

Deaths.

MANLEY.—On 4th inst., at New Street, West Bromwich, Herbert Manley, M.A., M.D., D.P.H., Barrister-at-Law, aged 57.

HILLS.—On 4th inst., at Prince of Wales Mansions, Battersea Park, Augustus Philip Hills, M.R.C.S. Eng., son of the late George Hills, M.D., F.R.C.S., aged 57.

Ed.—G. T. M.

GUY'S HOSPITAL GAZETTE.

VOL. XXVII., No. 650.] MAY 24, 1913. [SIXPENCE.

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Formal Opening of the New School Buildings.

AS we have announced in our recent issues, the Right Hon. A. J. BALFOUR, M.P., a Governor of the Hospital, has consented to open formally the New School Buildings comprising the new Laboratories of Chemistry and Physics, the new Pathological Department, and the new School of Dentistry on Tuesday, June 3rd.

The ceremony will commence in the Physiological Theatre about 2.20 p.m. The gallery of the Theatre will be reserved for students, and we take this opportunity of reminding men that they will not be able to obtain admission to the Theatre unless they send their names to the Secretary of the Students' Club on or before May 27th, when the seats in the gallery will be balloted for, and tickets issued to the successful applicants. The reason for this procedure is, of course, the extremely limited space available in the gallery, and the fact that the body of the Theatre will be completely filled by the guests of the School.

Our readers will hear with mingled feelings of relief and regret that academic costume will not be worn on the occasion. Each of us, no doubt, will be individually relieved at not being obliged to strut about in cap and gown, but collectively we deplore the absence of those outward and visible signs of that learning and eminence which distinguishes our School.

THIS forthcoming visit of Mr. BALFOUR will not be the first he has paid to the School in his public character. He came down to distribute the prizes at the Annual Garden Party in 1898. On that occasion he received a very hearty welcome from those present, and we need hardly remind men that he deserves an even more enthusiastic welcome this year. Nor have we the least fear but that he will receive it. Quite apart from the compliment he is paying the School, Mr. BALFOUR'S character and achievements are such as to command the admiration of any gathering of Englishmen.

Passim.

AS will be seen from the list of appointments for which applications are invited, very extensive changes have taken place in the Junior Medical and Radiographic Staffs. In the Surgical Radiographic Department it is proposed to retain the posts of Senior and Assistant Radiographers, the Senior Radiographer to attend on four afternoons a week, but not on Saturdays. The Assistant, who it is important to notice need not be qualified, will attend every morning and on one afternoon, but not on Saturday afternoon. His salary shall be £100 a year.

The Medical Radiographer will in future be known as the Senior Medical Radiographer. He will receive no salary, and will be appointed, as at present, biennially. He will attend four afternoons a week, and will be assisted, as we explain below, by the Medical Registrars. On Saturday afternoons the Radiographic Departments will be under the care of a Medical Registrar, so that in future patients seen late at Out-Patients will not have to wait till the following week before they can be X-rayed.

In future, also, thoracic and abdominal cases from the Surgical Wards may be examined in the Medical Radiographic Department, and, *vice versa*, joints and bones in the Surgical Department. This little recommendation, small and unimportant as it seems, removes a constant source of friction, and should do much for the smooth working of the departments.

THE number of Medical Registrars is to be increased to four, each to receive the same remuneration as at present. They will in future be known also as Assistant Medical Radiographers, and will work in pairs, one pair being for six months in the wards, whilst the other pair will spend alternate weeks as Radiographers, on the one hand, and working in the Clinical Laboratories and as Deputy Post-mortem Demonstrators on the other hand. The Medical Registrar, during his week as Radiographer, will attend the Medical Radiographic Department every day, morning and afternoon, including Saturday afternoon, when he will see the surgical cases in addition to the medical. He will be in charge of the department in the absence of the Senior Medical Radiographer, and will be expected to give demonstrations of the application of radiography to Anatomy and Physiology to men not yet in the wards.

The creation of four Medical Registrars and the apportionment of the work will, we feel sure, give general satisfaction. It has been very clear for some time that under the present regime a Medical Registrar has not had sufficient leisure to make full use of the material at his hand, and much less prosecute any original work with profit either to Medicine or himself.

The possibility of having his cases skiagraphed in the morning as well as the afternoon will come as a boon to the worried H.-P., long tired of finding how short a time two hours in the afternoon can be.

It has also been decided to appoint a qualified Dental Surgeon as Dental Radiographer. He is to be provided with a separate apparatus, and will attend daily in the Dental Department for one hour.

Two other appointments which are new appear on the list—namely, those of Chemical Pathologist and Morbid Histologist. The new Chemical Pathologist represents the present post of Clinical Analyst to the wards, with its scope greatly extended and enlarged and its salary correspondingly increased. The post of Morbid Histologist is an entirely new one. We will return at a later date to a more detailed account of the scheme under which these posts have been created, but we may explain that the new official will be in charge of all morbid histological work arising in the wards and post-mortem room.

SOME uncertainty seems to have arisen as to the exact significance of the circular recently sent to all Guy's men, setting forth the proposed changes in the Clubs' Union Year Book. We have been asked by a correspondent, whether

the old "life members" of the Clubs' Union will continue to be "life members" in the future, or whether they must subscribe a further guinea for re-admission to the privileges of the Union. The answer is, that all those who are at present "life members" of the Clubs' Union will continue as such without any further subscription. Those, however, who are not now "life members" can become so upon payment of one guinea, which guinea will entitle them, in addition to the Clubs' Union Directory, to the Reports, and the Gazette, free for one year from the date of joining, and will also further enable them to subscribe to the Gazette and Reports at the reduced fee of twelve shillings and sixpence per annum. This latter privilege is, of course, already available to the present life members of the Union.

All Guy's men, therefore, are asked to return the circular, filled up in the manner prescribed, but present life members need not accompany it with a cheque for one guinea.

We hear with much pleasure that the Medical School has just been presented with an epidiascope for use in the Anatomical Theatre by a generous donor. This gift puts the School in possession of two of these very valuable adjuncts to demonstrations. The other one forms part of the very complete equipment of the new Pathological Department. The epidiascope is very useful to the student in that it enables lectures to be illustrated far more fully and accurately than heretofore, but it is even more useful to the lecturer, especially to those lecturers who are not blessed with the gift of clear and accurate drawing. With this instrument the lecturer can prepare his illustrations by the light of the midnight oil, and then throw them fresh and accurate on the screen. We would, however, like to add a note of warning—namely, that we hope our lecturers will not fall into the facile but pernicious habit of tearing out the illustrations from books and using them instead of their own compositions. It is a trite remark that what is not absolutely clear to the lecturer is not at all clear to the lectured.

The Athletic Club's Annual Sports will be held this year on the Ground at Honor Oak Park, on Saturday, June 7th, and the United Hospital Sports will be held on Tuesday, June 24th. We understand that Dr. Herbert French has again kindly given prizes for a tug-of-war between the various years.

We would urge on all men the necessity for more keenness in entering and training this year if our own Sports are to be a success, and, still more, if we want to improve on last year's results in the Inter-Hospital Competitions.

We congratulate Mr. A. H. Birks on being appointed R.M.O.B. in succession to Mr. Geoffry Dunderdale, who, as we announced last week, has received an appointment in Colonial Medical Service, and is leaving shortly for East Africa.

The Eighteenth Annual General Meeting of the Guy's Hospital Ladies' Association will be held in the Court Room on Tuesday next, May 27th, at 3.30, when Her Royal Highness Princess Christian, the President of the Association, will occupy the chair. This Association, of which we hear very little in the hospital, has a membership of over 1,500 ladies, and affords the hospital a large amount of help, both practically in clothes for patients and in subscriptions which support the eight beds in Victoria and two cots, and also by helping to make known the good work done by the hospital.

Our congratulations to those gentlemen who were fortunate enough to navigate a successful passage through the rapids and whirlpools of the Primary Fellowship Examination. Six Guy's men were successful:—Messrs. J. G. Jones, C. E. Petley, K. N. Purkis, N. Reader, F. D. Saner, and J. C. Carter-Braine.

The results of the recent Dental Examinations are such as merit both our hearty congratulations to the successful men, and also to the School. As will be seen from the Pass List published in our columns, the list is a long one,

and analysis of it shows that 75 per cent. of the entrants passed Part I. (General Subjects) of the Final, and 78 per cent., Part II. (Dental Subjects). In the First Professional Examination, 66 per cent. passed in Mechanical Dentistry, and no less than 86 per cent. in Dental Metallurgy.

In the issue of *Vanity Fair* published on May 1st, appears a very admirable cartoon of Mr. W. Arbuthnot Lane from the talented pencil of Mr. Stanley Cock. Mr. Cock has just managed to catch "Willie" in a characteristic attitude. We feel sure that many old Guy's men will be very glad of this opportunity of obtaining a really good cartoon of their old "chief."

Overheard at Out-Patient's: — Jewish mother (giving an account of a swelling on her child's face): "Ven it vos swelled up, I vos put the hot 'inflammations' on it, and now it vos gone down."

G. T. M.

The Milward Fund.

SUBSCRIPTIONS FROM GUY'S MEN.

	£	s.	d.
Already acknowledged in Gazette	100	0	6
T. R. Atkinson, Chadwell Heath	0	5	0
L. A. Dunn, London	5	5	0
F. E. Fremantle, Hertford	5	0	0
and £5 a year for two years.			
*Sir A. D. Fripp, London	10	10	0
Thos. Morgan, Llandovery	0	10	6
R. O. Moon, London	3	3	0
F. J. Nicholls, Eastbourne	1	1	0
B. Rix, Tunbridge Wells	1	1	0
Charters J. Symonds, London...	5	5	0
R. H. Terry, Nelson, Glam.	1	1	0

*Sir Alfred Fripp's Donation was Ten Guineas. It was stated as Five Guineas in the last issue of the Gazette in error.

Particulars of the Fund can be seen in the last issue of the Gazette.

Further Donations will be gratefully received by the Hon. Treasurer, Mr. William Sheen, 2, St. Andrew's Crescent, Cardiff.

Pass List.

Royal College of Physicians.

At a Comitia held on 8th May the undermentioned was admitted a Fellow: W. H. Maxwell Telling, M.D. London.

Royal College of Surgeons.

The Licence in Dental Surgery has been granted to the following, who have now complied with the regulations on the subject: J. W. Hall, H. E. Shepherd.

LICENCE IN DENTAL SURGERY.

First Professional Examination, May, 1913.

Mechanical Dentistry and Dental Metallurgy.

†Allan, W. J. McB.	†Laver, C. H.
†Beacock, J. W.	Lowein, A. E.
Bernhard, P. E.	Mugford, J. L.
*Bevis, D. A.	†Neal, F. D.
Bryant, E. H.	*Oates, J. L.
Cook, C. A. E.	†Ordish, F. J.
†Corke, T. D.	*Pearce, D. G.
Curle, C. L.	Pearce, P. T.
*Dawson, E. A.	Rudd, F. E.
*Dean, A. C.	Ryland, R. J.
†Dee, G.	Small, D. F.
†Duff, K. M. K.	†Smith, S. G.
†Hill, J. J. S.	†Thom, M. C. V.
Hollands, W. G.	Turner, W. A.
†Howe, G. H.	†van Schalkwijk, P. L.
†Hugo, P. J.	*Viljeon, W. J. R.
Jessop, P. E.	†Wheldon, G. W.
†Johnstone, J. A.	Withers, S. A.

†Woolf, S. A.

*Mechanical Dentistry only.

†Dental Metallurgy only.

Final Examination, May, 1913.

Part I. and II.

*Barber, A. J.	*Neal, F. J.
*Isaacs, B.	*Saul, E. R.
*Marston, A. D.	*Thomas, C. E.
*Morrell, F. H.	*Williams, E. R.

Part I. only.

Adams, S.	King, P.
Bradley, R. G.	Montgomery, L. T.
Brown, A. A.	Pitman, K. C.
Bulleid, W. A.	Rix, R. H.
Cowell, R. G.	Rycroft, E. C.
Crocker, C. J.	Saunders, G. V.
James, H. G.	Smith, H. L.
Johnson, E. E.	Stevens, S.

Staley, R. C. W.

Part II. only.

*Ballard, R. W.	*Morrish, D. B.
*Charles, G. F.	*Neely, W. G. S.
*Clarke, A. S.	*O'Kane, W. J.
*Forrest, A. G.	*Purdom, H. N.
*Gaverick, R. H.	*Salsbury, A. F.
*Glover, C.	*Stainer, C. H.
*Haine C. F.	*Stradling, F. R.
*Hanreck, S.	*Warner, G. H.
*Henderson, T. E.	*Windermer, L. D.
*Hopson, M. F.	*Roberts, W. O.

M.R.C.S., L.R.C.P.

*Denotes completion of examination.

The Macroscopical Anatomy of the Human Premolar Teeth.

By G. F. CHARLES.

Paper read before the Guy's Hospital Dental Society.

Mr. Chairman and Gentlemen,—I think that the macroscopical anatomy of the human teeth is the "Cinderella" of our curriculum—left alone and uncared for by the majority of lecturers and students alike. We are too apt to pass over a detailed description, thinking that as we are treating them the greater part of the day, a minute knowledge of their macroscopical appearance should follow as a matter of course.

I propose, therefore, to give the results of my own examination of a large number of teeth which were collected by the Research Committee of the Dental Society, the use of which I was kindly allowed. Some of my generalisations may be severely criticised in the discussion which I hope will follow. Should I offend any one's ideas I must bear the blame alone, as my conclusions are original and not based on any text-book.

Before passing on to the macroscopical anatomy of the human premolars, it would, perhaps, be well to say a few words with regard to their comparative anatomy, about which I had recourse to Mr. Tomes' Dental Anatomy. In the typical mammalian dentition there are 16 premolars, four on each side of the mandible, and four on each side of the maxilla. Now the premolars are lost from the front of the series, and consequently those missing in man are the first and second premolars. With regard to the primates, the lemurs have the premolars laterally compressed, and the cusps are sharp pointed; those on the mandible have two roots which are situated labially and lingually.

In the old-world monkeys, except the anthropoid apes, the upper premolars have three roots; in the mandible the first premolar is two rooted, the roots being placed anteriorly and posteriorly; the anterior root is produced forwards and the apex is almost over the posterior root. It articulates with the upper canine by its anterior surface. The second premolar has two roots.

In the anthropoid apes, for example, the orang, the first upper premolar is caniniform, while the second is blunter, both having three roots. In the mandible the premolars are shorter and stouter and caniniform, the second one having its internal cusp as high as the external. They have two roots placed anteriorly and posteriorly.

In the new-world monkeys the upper premolars have bifurcated tips to the roots. In the lower, the first premolar is badly developed, but an increase in size is noticed in the second and third premolars; they are single rooted.

In mammalia the first premolars rarely displace a deciduous tooth as in man. As the species become more highly specialised there is a tendency to fewer teeth with fewer roots.

I will now pass on to the discussion of the human premolars. The premolars are those teeth which are situated between the canine and molars, and vertically displace the deciduous molars. They are eight in number, two on each side in the maxilla and two on each side in the mandible. Structurally they are similar to the other teeth in the mouth, consisting of of a crown composed of hard dentine and covered with enamel, a root formed of hard dentine and covered with cementum, the whole enclosing a pulp cavity. The teeth are socketed and connected to the periosteum of the bone by a periodontal membrane.

The upper first premolars are the most variable, differing not only in the number, but also in the size of their roots; the lower premolars, however, are fairly constant, their differences being mainly in the size of the lingual cusp, especially of the first premolar, and the convexity of the buccal surface. Two-rooted and even three-rooted lower premolars are met with, but this is of comparatively rare occurrence.

I have not been able to discover in any one mouth, or from the teeth I have had to examine, any appreciable differences between the premolars of either side, though, of course, in those cases where the teeth are abnormal this rule would not necessarily apply, and so it would be a waste of time to consider them separately. The upper first premolars are the largest of all the premolars.

The crown is quadrilateral in shape, consisting of a body surmounted by two cusps, which are separated by a transverse groove (1) (2). The distance between the cusps is equal to the length of the groove, and in cases where the teeth are laterally compressed the tips of the cusps bend slightly over, and so this relationship is maintained. The cusps are not equal in size, the buccal one being the larger and more pointed; it is triangular in shape, and of the two sides which form the angle at the tip, the anterior one is the shorter. This angle is of a very varying degree; it is rarely less than 90 degrees. The outer surface of the cusp is not quite even, but at points corresponding to the ridges on the inner side there will be noticed slight depressions which, in some teeth (3), cause the cusps to simulate the appearance of having three cuspules; below these depressions the enamel bends in slightly, and then out again, recurving over at the neck of the tooth. The ridge thus formed is sometimes very distinct, and may be continued round the tooth.

The palatal cusp is very variable in size; generally it is smaller, but it is not uncommonly found equal. It is nearly a reproduction of the buccal cusp, except that it is more rounded and that the palatal surface is smoother. The transverse fissure which divides the two cusps breaks up into three divisions, anteriorly and posteriorly respectively; the two middle ones are continued to the edge of the tooth; the two external ones are continued upon the buccal cusp, and the two internal ones on to the palatal cusp, thus causing a slight elevation on each cusp.

The enamel does not end at the same level on the whole of the tooth. On the buccal and palatal surfaces it is at about the same level, that is, at a distance from the tip a little bit longer than the length between the cusps. Mesially and distally the margin curves up and is higher than it is on the other two sides. The whole margin is about one-eighth to one-sixteenth inch under the gum, this length varying according to the condition of the gum.

I examined the roots of 61 upper first premolars (4) (5), and the following are the results:—

15 had 2 roots with the bifurcation high up.

15 had 2 roots with the bifurcation not so marked.

8 had 1 root with slight bifurcation at the apex.

All these teeth had two definite root canals.

20 had 1 root with no bifurcation, but distinct mesial and distal grooves.

3 had 1 long tapering root.

Or 60 per cent. present bifurcation with 2 definite root canals, while 40 per cent. had only 1 root, and the presence of 2 root canals could only be detected by internal examination.

In describing these roots I will first take those teeth that have 2 definite roots. The outer surface of the buccal root is in a straight line with the face of the tooth, while the inner surface is quite even and rounded. The palatal root is more irregular in shape, though this irregularity is often found on the buccal root; the internal or palatal surface dips inwards at the point of bifurcation, then bulges out, curving in again at the apex; the roots separately are rounded, the space between them being V-shaped. Mesially there is a distinct concavity at the neck. In those teeth with only one root the external surface is in a straight line with the face of the tooth, while the palitine surface slants outwards to meet it. There is a distinct groove mesially and distally, which is more distinct in the former. In some teeth this groove is rather indistinct, possibly indicating one root canal.

A transverse section taken just below the two cornua of the pulp (6) shows the pulp chamber to be oval in shape with no constriction. The pulp chamber lies in the centre of the tooth (7), and an opening made through the centre of the transverse groove on the crown would emerge in the middle. But it should be remembered that the pulp chamber should be fully opened up before the root canals are approached, as they are placed at either end of the pulp chamber.

On longitudinal section the whole of the pulp chamber, with its two root canals, will be disclosed. They will be found to conform more or less to the shape of the tooth (8). The pulp chamber is oval in shape, with two cornua going into each cusp, the buccal cornu being about twice the size of the palatal one. At a point just below the level of the termination of the enamel the two root canals are given off. These run through the middle of the roots, ending at their apical foramina; towards the latter part of their course they become very fine, while the apical foramen is hardly noticeable.

The root canals, as I stated above, do not come off from the middle of the pulp chamber, but at either end, and are directly continuous with the two cornua. This appearance of the root canals tends to support the multicusped theory of the development of the teeth, held by Rose, etc., as the tooth on section looks as if at one time it consisted of two cones with single pulp chambers, and that in course of time they had become fused and the pulp chambers joined.

In those cases where the teeth have one root, but two canals, the same condition is found (9), except that the pulp cavity is longer and the canals are parallel instead of divergent. In some teeth these two root canals become joined (10). Here the pulp chamber is continuous with the root canal, the latter being much broader than those in former cases. The size of the pulp chamber is variable, but, as a general rule, its length is equal to one-half the thickness of the tooth at the neck, and breadth is about one-quarter the distance; on transverse section it is just like a narrow slit.

The second premolars are smaller and rounder than the first, but in their general shape they are very similar. There seems, however, to be some dispute with regard to their size in comparison with the first premolars, and going round in the conservation room one found in the majority of cases that the crowns were not only smaller, but as I stated above, more rounded, and this applies especially to the buccal cusps. Also the cusps, as a rule, seem to be more equal in size, and there was not the difference that was noted in the first premolars (11, 12).

Out of 31 examples of such teeth, I found only five had two roots. In nine there was one root which curved back towards the molars. In seven the root was straight with a slight curve back at the apex. In seven others the roots, though also straight, did not curve back. In three the roots curved towards the front.

On the majority there was a median ridge, mesially and distally, and the roots were longer than those of the first premolars.

The buccal surface is straight with that of the tooth, but the palatal surface slants outwards to meet it at the apex (13, 14).

The roots are flattened from side to side, and rather tapering, with a decided curve backwards, though the intensity and size of the curve varies.

Two rooted second premolars are not so common as one would expect; of the teeth I examined, 16 per cent. had two roots. Single roots, with two-root canals, however, are more common, though I have no figures to qualify this statement.

A transverse section of the tooth taken just below the level of the cornua shows the pulp chamber to be oval in shape, with a marked constriction in the centre; this latter often causes trouble in reaming; and in some cases it is so marked as to lead one to suppose that there are two root canals (15).

On longitudinal section the whole of the pulp chamber, with the root canals is disclosed. The palatal cornu is not quite so prominent as in the first premolar, but the buccal cornu is about the same (16).

The root canal is larger than those of the first premolar, and is more regular in shape, it tapers to a fine point at the apical foramen.

A section of a two-rooted second upper premolar shows a very long pulp chamber and two small root canals, placed in the same manner as in a two-rooted first premolar (17). From a developmental point of view the lower premolars are very interesting, and with regard to the first premolars, they help to show not only their connection with the canine, but also the reason why the latter is called by Mr. Tomes, a "caniniform premolar." The first lower premolar is the smallest of all the premolars, and in many cases has the appearance of a canine with a well developed ungulum. The shape of the crown is oblong, which gradually becomes round lower down towards the neck. The length between the two cusps is equal to about half the width of the tooth (18, 19).

The crown consists of two cusps joined together by a transverse ridge. This ridge is very irregular, sometimes it is absolutely straight, as in the model I am passing round, in other teeth it has the appearance of a fractured bone, where the two pieces have slipped to one side. On each side of the ridge is a deep triangular pit, into which the palatal cusps of the first upper premolars articulate. The buccal cusp is by far the larger; it is triangular in shape, and of the two sides which form the angle at the cusp, the mesial one is the shorter. This angle is not very noticeable, owing to the great convexity of the buccal surface, and the rounded condition of the cusp. The buccal surface is very wide just below the tip, while at the neck it is somewhat constricted. The external surface is not quite smooth, having two lateral depressions of varying degree. The buccal cusp is very variable in the amount of its convexity, and in some cases it is almost straight.

The lingual cusp is very small and leaves little to describe. It is very blunt, and practically in a straight line with the root. It is very variable in size, from half the size of the buccal cusp to complete absence (20).

In the lower first premolars I examined (about 70), the enamel reached down to a greater extent on the labial than on the lingual surface, whilst mesially and distally it curves up over the root as in the upper premolars.

The ridges and grooves on the crowns of the lower premolars, and also on the upper, but not to such an extent, are often exaggerated, causing them to have the appearance of possessing additional cuspules. The general tendency of the roots of the first lower premolars is to be rounded, but out of thirty-six that I examined, ten were decidedly round, eighteen somewhat laterally compressed, six flat with a well marked mesial groove, two bifurcated. The roots are long in comparison with the crown, and rather tapering; in some there is a tendency to a curve backwards at the apex (21, 22).

Just as the buccal cusp is the larger, so the buccal surface of the root is larger than the lingual, though not to such a degree. The lingual surface of the root is straight with the long axis, but the labial surface slants inwards to meet it at the apex. On transverse section, the pulp chamber is oval in shape, being about four times as long as it is broad. In opening up the pulp chamber care should be taken not to go between the two cusps, or else one would open on to the lingual side of the root canal, but to take a point about half way, or even at the tip of the labial cusp, which owing to its convexity bends right over the pulp chamber (23, 24).

On longitudinal section, the pulp cavity will be seen to be similar to that of a canine. There is only one cornu—in the labial cusp; though I believe a second cornu is sometimes found in the lingual cusp, but feebly developed (25, 26, 27, 27A).

The pulp chamber tapers at either extremity, being widest at a level corresponding to the neck of the tooth. As far as I am able to tell from the teeth at my disposal, the root canal is situated in the centre of the root, ending in the same manner as in the other premolars. The lower second premolars are more akin to the shape of the upper second premolars, at least with regard to their crowns. These are quadrilateral in shape, the longer side being antero posteriorly, and consist of two cusps joined together by a transverse ridge, with a triangular depression on each side (28, 29).

This ridge, however, has a more distinct groove running across it. The buccal cusp is similar to that of the upper second premolars, but it is much smaller, and the outer surface is convex, though not to such a degree as in the first lower premolars. The lingual cusp is larger than in the first premolars, and is sometimes found larger than the buccal cusp. In all other respects the crowns are similar to those of the first premolars, but larger. The shape of the root is round, the lingual surface being smaller than the labial surface. Out of 42 that I examined, eight were distinctly round, eighteen

aterally compressed and curved back towards the molars, eleven were straight, three had two roots, two curved forwards. The lingual surface tends to be straight with that of the lingual cusp, whilst the labial surface curves in to meet it. On transverse section the pulp chamber is oval, the length being about five times the breadth, and so larger than that of the first premolar (30, 31).

In opening up the pulp cavity a point should be taken about half way up the buccal cusp in the centre (32, 33). On longitudinal section the pulp will be seen to have a cornua, though that for the lingual cusp is not very large—about one-third the size of the buccal cornu. The pulp chamber in the lower premolars has a less proportion to the size of the tooth than in the upper premolars. The root canal is placed in the centre of the root, and ends at the apical foramen (34, 35).

Before concluding, there are a few remarks I should like to make which were suggested to me by a paper written by Mr. D. M. Shaw, where he brings three things of import to our notice.

First, that the plane in which the outer surface of the buccal cusp of the first and second upper premolars lies, is standing outwards towards the cheek from mesial to distal; and so the mesial surface is narrower than the distal. The consequence is that the palatal cusps are brought round and are more mesial. I have examined a good many of the teeth in my possession, and have found them to agree with this.

Secondly—and this follows on the first point—, that the palatal cusps of the upper premolars bite into a triangular pit on the distal sides of the crowns of the lower premolars, and not between the premolars, and premolar and molar, as was commonly thought. Mr. Shaw points out that it would not be consistent with nature to have a force which would be constantly tending to separate and drive food, etc., between the teeth. I am passing round models to show this articulation. And, thirdly, that on the mesial surfaces of the first upper premolars, just at the neck, there is a distinct concavity; this is formed during pre-eruption days. There is not sufficient room for the convex distal surface of the permanent canine, and so this concavity is formed in the mesial surface of the first upper premolars in which it may fit (36, 37, 38, 39).

Mr. Shaw maintains that in any upper first premolar where the crown has been taken off, it is possible to tell which side is mesial, on account of this concavity. I only know that I have noticed it in many of the premolars in my care.

After all, the variations in the macroscopical anatomy of the human premolars are so great that the task of anyone who sets out to describe them is at the best an unsatisfactory one. I only hope I have been able to define the limits within which these variations lie. But the description of these teeth must be somewhat tedious, and for your patient hearing I thank you.

*The numbers in parentheses refer to the models, which were passed round and are now in the Museum.

Papers by Guy's Men.

A. S. Blundell-Bankart, M.C., F.R.C.S.: Treatment of Congenital Dislocation of Hip (with special plate).—*British Medical Journal*, 17th May, 1913.

C. H. Fagge, M.S., F.R.C.S.: Chronic Intestinal Stasis.—*Lancet*, 10th May, 1913.

Sir Jas. F. Goodhart, M.D., F.R.C.P.: Alimentary Toxæmia.—*Lancet*, 17th May, 1913.

T. B. Layton, M.S., F.R.C.S.: Dental Access to Nasal Sinuses.—*British Dental Journal*, 15th May, 1913.

Lawrie McGavin, F.R.C.S.: Remarks on Transverse Colostomy as the Operation of Election.—*British Medical Journal*, 10th May, 1913.

Captain A. C. Osburn, R.A.M.C.: Result of the Combined Method of Treatment on Gonorrhœa.—*R.A.M.C. Journal*, May, 1913.

H. Watts, M.B., B.S. (Lond.), Capt. I.M.S.: Appendicitis in a Hernial Sac.—*Indian Medical Gazette*, March, 1913.

Change of Address.

A. Neville Cox, M.B., B.S., to 12, Burlington Street, Marine Parade, Brighton.

J. Levy, L.D.S., from Park Lodge, Highbury New Park, N., to 1, Bloomsbury Square, W.C.

G. B. H. Jones, M.R.C.S., L.R.C.P., to Belgrave Hospital for Children, Kennington, S.E.

A. H. Miller, M.D., from 4, Benét Place, Lensfield Road, Cambridge, to Foxton Hall, Royston, Herts.

H. P. Warner, M.B., B.S., from Hants County Hospital, Winchester, to Belgrave Hospital for Children, Clapham Road, S.W.

T. N. Wood, M.B., B.C., from Woodlands, Gravesend, to The Gothics, East Bergholt, Suffolk.

(*The Editor will be very glad to receive a postcard with notes of any change of address.*)

Gazette Special Pathologist.

H. L., MANCHESTER.—This tumour is a neuro-fibroma composed of interlacing bundles of delicate connective tissue of the neuroglia type. It is enclosed in a fibrous capsule in which an occasional nerve fibre can be seen. It is not malignant.

H. L., MANCHESTER.—The bulk of this material has undergone so much necrosis that it is not possible to be quite sure of its nature. It has the appearance of myxomatous tissue or immature cartilage enclosed in a connective tissue stroma, and does not suggest histological malignancy.

PATHOLOGIST.

Preparation of the Patient for Abdominal Operations,

And some Points on the After-treatment.

CLINICAL LECTURE BY R. P. ROWLANDS.

Preparation of the Patient.

Gentlemen,—Except in emergencies, it is advantageous to admit the patient into the Hospital or Nursing Home a day or two before an abdominal operation. Not only is the rest valuable for the patient, who also gets used to his attendants and surroundings generally, but he can be *systematically examined*, with the double object of ascertaining if he is a fit subject to undergo the operation, and of making a more accurate diagnosis. For instance, X-ray examinations of the stomach and intestines after bismuth oxychloride has been given, often reveal new and valuable facts.

After a hot bath the abdomen is generally shaved, rubbed well with acetone or benzine, painted with tincture of iodine, and covered with a sterile pad. This is done in the ward. On the table the abdomen is again painted with iodine. For all abdominal operations, it is important to pay special attention to the diet, and to get the bowels thoroughly emptied, for in this way the virulence of the intestinal contents is lowered, and the comfort of the patient during the first few days after the operation is greatly increased. In nearly all cases a brisk aperient like calomel gr. V., or castor oil 1 oz., is given about thirty-six hours before the operation, and this is followed by a saline aperient early next morning, and, if necessary, by a soap enema. In some cases the enema is repeated on the evening before the operation. The patient should keep in bed on the day before the operation, and should take only light and sterilized food. This consists almost entirely of liquid, such as milk, soup, and beef-tea. In some cases, especially of gastric dilatation, it is an advantage to give only solid sterilized food, such as eggs, jelly, and salad oil by the mouth, and all necessary liquid in the form of saline enemata, night and morning. In some cases it is an advantage to have the patient admitted three or four days before the operation. This is particularly so in cases of extreme pyloric obstruction, requiring gastric lavage and saline enemata, cases of chronic intestinal obstruction requiring repeated doses of aperients, and obscure urinary cases requiring careful investigation. It is also valuable when the mouth is septic, and there are carious teeth or pyorrhœa alveolaris. The teeth may require scaling, some of them may have to be removed, and others temporarily stopped. In any case a clean tooth brush, and mouth wash should be used frequently during the day. These precautions are valuable in preventing pneumonia and parotiditis after the operation.

After-treatment.

Much of the increasing success of abdominal operations depends upon careful after-treatment. It is a common mistake to interfere too much, for it is sometimes difficult to know when to leave well alone; but, on the other hand, treatment for some of the complications to be mentioned below, has to be prompt to save life. Usually there is very little to be done beyond careful nursing, attention to the diet and general comfort of the patient. The difficulty lies in knowing quickly when things are going wrong. As far as possible complications should be prevented by care and untiring attention to detail before, during, and after, operation.

1. *Posture.*—When returned to bed the patient has only one small pillow under his head and is rolled slightly to one side with another pillow behind the shoulders. This lessens the risk of the aspiration of vomit and enables the patient to breathe more freely as the tongue does not fall back. The nurse never leaves him until he has regained consciousness. About two hours after the operation the patient is usually placed in the oblique position with his shoulders well raised by pillows or some mechanical contrivance. In this position he is much more comfortable and breathes more easily; pulmonary complications are less likely, and after gastro-enterostomy the contents of the stomach drain away more freely into the

intestine. After operations for appendicitis with suppuration, the sitting-up, or Fowler position, tends to limit the infection to the pelvis; it also facilitates drainage soon after operations for general peritonitis. For some operations upon the biliary apparatus it is, however, an advantage for the patient to keep nearly flat for about twelve hours until limiting adhesions have formed to prevent leakage of bile into the peritoneal cavity.

From the first the patient is encouraged to move his feet and legs in order to prevent wasting. In some cases massage of the limbs is very useful for the same reason. Free use of the limbs and a change of position by the nurse at first, and later by the patient, also tends to prevent thrombosis with pulmonary embolism. Change of position and active movements are valuable also in preventing pulmonary complications. For the same reason it is not good for the patient to be kept in bed too long. In most cases the patient can be lifted on to a couch at the end of four or five days and begin to walk at the end of a week or ten days. I believe that stagnation in bed is one common cause of thrombosis, pulmonary embolism and pulmonary complications generally. After many operations the patient can safely leave the hospital or nursing home for a convalescent home at the end of a fortnight, but it is rarely wise for him to return to work under three or four weeks from the date of the operation. A too early return leads to an incomplete recovery.

2. *Shock.*—To lessen shock, the head is depressed, the abdomen is firmly supported by a many tailed bandage, and sometimes by a large towel in addition, and the patient is kept warm with blankets and hot water bottles. In many cases an infusion of about one pint of warm normal saline solution (temperature 105° F.) or an isotonic solution of dextrose is given into the middle of each axilla immediately after the patient is returned to bed; and an ampoule of pituitary extract is injected either intramuscularly or directly into a vein. In a few cases of great urgency, when the circulation is too poor to absorb the saline solution from the armpit, it is given directly into a vein, usually the median basilic. No more than three pints are to be given at a time for fear of causing œdema of the lungs. It is better to repeat the injection, after two hours, if necessary. In most cases it is sufficient to give a saline enema of one pint, containing 20 to 30 grains of aspirin, very slowly. The aspirin eases pain. Half-a-pint of saline is administered by the rectum, every three or four hours, until vomiting has ceased and the patient is taking enough liquid by the mouth. In other cases warm saline solution is continuously and slowly administered by the rectum. The rectal tube should have several apertures, and should not be too long or have too small a lumen. Otherwise flatus cannot escape, with the result that the saline is not retained. This is especially valuable in cases of peritonitis when as many as five or six pints are often given in twelve hours. There is no advantage in giving more. In most cases the enemata are not required after twenty-four or thirty-six hours. They lessen thirst, shock, and vomiting.

3. *Thirst.*—This is also alleviated by making the patient wash out the mouth with water or a weak solution of bicarbonate of soda, and especially by the frequent cleansing of the mouth by the nurse with lemon juice and glycerine or glycerine and borax. The teeth are thoroughly cleaned, at least, twice a day with a clean tooth brush and an antiseptic solution, such as listerine. The tongue is also thoroughly cleaned with lint, moistened with glycerine and borax. These precautions, besides adding to the patient's comfort, greatly diminish the risk of pulmonary complications from the aspiration of septic material into the lungs. They also make ascending septic infection of the parotid gland very rare at the present day.

4. *Vomiting.*—For various reasons vomiting after operations is not nearly so common or severe as it used to be a few years ago. More perfect asepsis, the better administration of anæsthetics, especially the almost universal adoption of open ether following morphia and atropine or scopolamine, which lessen the amount of anæsthetic used, and the more common use of saline infusion, in one way or another, all lessen the severity of vomiting.

Keeping the patient's head low and turned to one side during the administration of the anæsthetic, in order to prevent swallowing of mucus saturated with the anæsthetic, also helps to prevent vomiting from the direct irritation of the stomach by the anæsthetic. It is often a good plan to let the patient take a good drink of warm solution of bicarbonate of soda to wash out the stomach. When the vomiting continues after twenty-four hours other causes than the anæsthetic must be considered. In many cases it is due to partial paralysis and over-distension of the stomach. In any case lavage should be tried, the stomach being thoroughly washed out with a weak solution of bicarbonate of soda. If this does not stop the vomiting there is usually a more serious cause, such as peritonitis or intestinal obstruction. In these conditions the contents of the intestine regurgitate into the stomach and vomiting continues. Occasionally it continues for several days after the operation, apparently without any adequate cause. These patients are mostly very nervous women. In addition to washing out the stomach, warm applications or even a blister may be applied to the epigastrium, and a dose of potassium bromide, 25 grains, and chloral hydrate, 25 grains, may be given by the rectum. In some cases the vomiting may be due to acute dilatation of the stomach and the possibility of this is always to be remembered. At first there is bulging of the epigastrium and, later on, the whole abdomen becomes enormously distended. Small quantities are brought up at frequent intervals. The stomach tube should be passed at once and the stomach thoroughly emptied and washed out, and the position of the patient should be changed as suggested by Moynihan, who recommends the prone position with elevation of the pelvis. This complication is fortunately a very rare one and can, I believe, be prevented by resorting to lavage early enough.

5. *Food.*—When the vomiting has ceased, water is given by the mouth, at first in small quantities, but if it does not cause vomiting, it is rapidly increased. After twelve to twenty-four hours, equal parts of milk and water or barley and water are given in small feeds, such as one to two ounces every hour. In many cases weak tea is also given early, and is often liked and retained when milk is not. After twenty-four hours, milk thickened and flavoured in different ways, soup or beef-tea and jelly are given; also lemonade or orange, or grape juice. On the third day thin bread and butter, milk puddings and lightly boiled eggs are given, and on the fourth or fifth day more solid food in the form of fish, sweet-bread or chicken is given. All milk and food given in the early days after the operation should be sterilized. Occasionally, vomiting and diarrhœa prevent the absorption of anything administered by the mouth or rectum. Saline infusions into the axillæ or thighs, given slowly and continuously, or intermittently, usually suffice. In some cases sterilized olive oil or normal horse serum is given subcutaneously.

6. *Pain.*—For the relief of pain aspirin, 10 grains by the mouth or 20 to 30 grains by the rectum, usually suffice. In some cases, however, when the pain is severe or the patient feeble and exhausted from want of sleep, a small dose, such as one-eighth or quarter grain of morphine, may be given in the evening. It is rarely wise to repeat the dose, for morphine paralyzes unstriped muscle, increases flatulence, and tends to produce paralytic distension of the bowel.

7. *Urine.*—As a rule, very little urine is secreted during the first twelve hours after an abdominal operation. The patient should be encouraged to empty the bladder at the end of twelve hours, and regularly every four hours after this. In this way paralytic distension of the bladder can be avoided. If there is any difficulty, it is an advantage to turn the patient on his side and to apply hot fomentations or give an enema. If there has been no relief within twenty-four hours, a boiled soft rubber catheter is passed with due aseptic precautions. Afterwards, the patient should be encouraged to empty the bladder every four hours, in order to avoid a repetition of the trouble. If necessary, the catheter is passed every eight hours, until the power of the bladder has returned. In some cases retention of urine is overlooked, because the patient passes water in small quantities at short intervals. This means paralytic dis-

tension with overflow, and when a catheter is passed a large amount of urine may be found in the bladder. This condition may not develop until several days after the operation. For this reason it is of great importance to measure the urine for the first few days. The patient generally passes about one pint in the first twenty-four hours, and afterwards should pass at least two pints every twenty-four hours.

8. *Flatulence.*—If there is much flatulence, this, when chiefly gastric, is often relieved by propping the patient well up and by occasionally giving spiritus ammon-aromat, or a drop of peppermint oil on a small piece of bread by the mouth, and immediately washing it down with water. Intestinal flatulence is often relieved by passing a rectal tube (with several side holes) into the lower part of the rectum and leaving it there for some time. In extreme cases a turpentine enema (oil of turpentine 1 ounce, mucilage of starch 15 ounces) is used, and rarely fails to afford relief. Pituitary extract often acts like a charm.

9. *Purgatives.*—Usually the rectum is washed out with a pint of soap and water every morning. It is rarely necessary or wise to give any aperient by the mouth until the evening of the third day, when pil. col. et hyos. gr. 4 to gr. 8 may be given, followed by a saline draught in the morning, and, if necessary, by an enema. In some cases one ounce of castor oil is given early in the morning and followed by a saline purge and an enema, if necessary. In some obstinate cases an enema containing turpentine ʒi., glycerine ʒ½, and mag. sulph. ʒi. is very effective. This has the advantage of allowing the patient a comfortable night. Afterwards some mild aperient such as cascara sagrada, infusion of senna pods or liquid paraffin is given if required. In many cases, especially acute abdominal conditions such as appendicitis with suppuration, or where peritonitis, from whatever cause, is feared, it is better not to give any aperient by the mouth within the first four days. It is not wise to increase peristalsis in these cases, for the movement of the bowel tends to disseminate infective material. Generally the bowels act spontaneously on the third or fourth day, especially when the lower bowel is kept empty by the daily wash-out.

The bowels are generally almost empty at the time of the operation, and there is no advantage to be derived from giving purgatives in the first few days. In cases of peritonitis not only are purgatives often ineffective, but they also add greatly to the patient's discomfort, act as irritant poisons, and tend to increase paralytic distension. It is only an ancient superstition that recovery from peritonitis depends on free purgation. Calomel, even in small doses, given repeatedly, is especially dangerous when it fails to act.

10. *Dressing the Wound.*—When the wound has been completely closed it is rarely necessary to disturb it for about ten days, although a tight bandage may need to be re-adjusted and excess of dressings may need removing. When the wound has been drained by a split tube with a wick of gauze, the tube is not disturbed for at least four days, although the wick may be changed daily if necessary. There is no advantage in removing the tube too soon, for a re-collection may occur in the deeper parts of the wound. There is no need to remove the tube for boiling or cleansing; it is sufficient to wash the wound with peroxide of hydrogen or other weak antiseptic solution. Syringing is unnecessary, painful and dangerous.

Complications.

Most of these have already been mentioned, but it is well to consider some of them more fully.

(*a.*) *Hæmatemesis.*—This sometimes follows gastric operations when the sewing is at fault. Apart from this the vomit may be black from altered blood. This is a very grave sign and usually indicates an acute septicæmia with oozing of blood from the mucous membrane of the stomach and upper intestines. It also sometimes follows the use of purgatives which are retained in the bowel and act as powerful irritants. It is especially liable to follow calomel given in small doses repeatedly. Most of the patients who develop this symptom die. The best thing to do is to wash out the stomach

repeatedly if the condition of the patient allows this. In some cases small doses of adrenalin chloride may be given by the mouth and saline infusion into the axillæ. Large enemata are also given.

(*b.*) *Peritonitis.*—That this is a very rare complication at the present day is chiefly due to the careful precautions taken during operations to prevent leakage or contamination. We owe much to the careful and routine use of clamps and packs. The adoption of continuous sutures instead of mechanical devices, such as Murphy's button for making anastomosis, is also a great safeguard against sloughing and secondary leakage, which used to be more common. The universal adoption of rubber gloves has done a great deal to exclude extraneous infection. Occasionally, however, peritonitis does develop after an anastomosis of the lower part of the small intestine for intestinal obstruction. It is of very great importance to recognise the condition, for it is well known that a secondary peritonitis is easily overlooked, and has a very high mortality. It is rarely worth while to open the abdomen when the disease is well developed, but if the condition is recognised quite early re-opening the abdomen and adequate treatment of the cause with free drainage of the peritoneum is always worth doing. The early signs of peritonitis are therefore of great importance. These are pain and restlessness, with an increasing pulse rate from 110 to 140. The pulse always becomes weak, and the patient is soon cold and clammy with an anxious expression. The knees are drawn up, sometimes there is vomiting or hiccough, sometimes the temperature goes up, but, above all, the abdomen becomes tender, fixed, and rigid. These signs are especially ominous when they present themselves in the flank, where they cannot be mistaken for the natural tenderness around the wound.

(*c.*) *Intestinal obstruction* sometimes follows abdominal operations, but is not always due to them. It is especially likely to happen from kinking after incomplete operations for suppurative appendicitis. Occasionally a kink occurs above an anastomosis and bands or accidental hernia, either into the deeper parts of the wound or into the omentum, or mesentery may occur. It is of vital importance to recognise the condition while it is still hopeful. The most important signs are persistent vomiting in spite of lavage, the vomit gradually becoming bilious, and later brown and foul. Meanwhile, the pulse is slow, and the patient in much pain and collapsed. The bowels fail to act in spite of repeated enemata. The secretion of urine is almost abolished, and abdominal distension increases with visible peristalsis in some cases. When the condition is strongly suspected, the abdomen should be opened without delay, and the condition dealt with as may seem fit.

(*d.*) *Pulmonary Complications.*—Attention has already been drawn to the great importance of keeping the mouth clean, and of the sitting-up position. Care should also be taken to prevent infection from the anæsthetic apparatus, or from the aspiration of vomit during or after the anæsthetic. For this reason it is of the greatest importance to wash out the stomach before the operation in many cases of intestinal obstruction, and also of gastric dilatation. The abdominal bandage should not be tight enough, or extend high enough, to restrict breathing, and the patient should be encouraged from the beginning to take deep breaths several times daily. Compression of the bases of the lungs should also be avoided during the operation. For this reason the Trendelenburg position, when required, should not be maintained longer than necessary. When intravenous infusion of large quantities of saline solution was common, pulmonary complications were sometimes secondary to œdema of the lungs, and that is one of the reasons why axillary infusion, and especially rectal salines, are much better than intravenous infusion in the great majority of cases, for the blood pressure is never raised so much or so suddenly by them as it is by intravenous infusion.

The anæsthetic, especially ether, has been held responsible for pulmonary complications following operations, and there is no doubt that the chilling effect of ether on the lungs of old people, especially those already subject to chronic bronchitis, is detrimental, and for them

C.E. or chloroform is to be preferred. It is very important to avoid undue exposure of the patient before, during, and after operation. He should be warmly clothed and shielded from draughts, especially when collapsed after the operation. With the same object in view, the theatre should not be too hot, so that the contrast may not be too great. Too frequently the patient, drenched with perspiration in a hot theatre, is carried to a comparatively cold ward. I firmly believe that it is rarely advantageous to have the temperature of the theatre above 65, for not only does the free perspiration commonly seen predispose to chills, but it also increases shock.

The most common pulmonary complications are pneumonia, especially of the lobular type, bronchitis, pleurisy and empyema. They are particularly apt to follow operations in the upper abdomen, which more commonly limit the movements of the diaphragm. They are undoubtedly due to septic embolism in a great many cases, and this is an additional reason for providing efficient drainage in septic cases and for removing a diseased appendix and its blood vessels in cases of suppurating appendicitis. A post operative empyema is particularly likely to be overlooked. An exploring needle should be inserted whenever there is reasonable suspicion of its existence.

(*e.*) *Thrombosis and Embolism* are mostly due to stasis and sepsis of the blood. Too complete rest in bed lowers the force and frequency of the heart beat, retards the circulation, and predisposes to clotting. For this reason the patient should be turned and moved *about fairly freely from the beginning*, and should be encouraged to move his limbs freely. For the same reason it is important to get the patient out of bed after an operation as soon as possible. It is also an advantage in many cases, especially when the pulse is weak and slow, to give small doses of strychnine. It is said that a too exclusive milk diet predisposes to clotting on account of the large amount of lime salt. There is no doubt, however, that the clot contains bacteria, often of low virulence in nearly all cases so that phlebitis frequently precedes or accompanies thrombosis. For this reason it is of great importance to aim at perfect asepsis throughout abdominal operations, and also to avoid injury to veins especially in dealing with septic conditions. For the same reason it is important to open abscesses early and to drain them thoroughly without allowing the tube to press upon the veins. It is especially noteworthy that thrombosis is particularly liable to follow pelvic operations, especially hysterectomy. In these cases it is probable that a mild septic inflammation, short of suppuration, prevails in the tissues of the pelvis and causes inflammation of the iliac veins. As is well-known the left leg is the one most commonly affected. For various reasons the venous return from this leg is poorer than from the right. When signs of thrombosis develop it is important to keep the patient at rest for at least three weeks so as to avoid, as far as possible, the risk of embolism.

Pulmonary embolism, as a rule, is an unforeseen catastrophe, for in the majority of cases there has been no indication of a previous thrombosis, although organized clot taken from the pulmonary artery and floated in water sometimes shows by its shape that it has previously occupied a large vein and its tributaries. Usually this is the internal iliac vein, an examination of which, after death, may show impacted clot or signs of phlebitis. In other cases the clot is formed in the right auricular appendix. In some cases the embolus is not large enough to completely block the pulmonary artery so as to cause sudden death, but spreading thrombosis may gradually complete the obstruction. In many cases smaller emboli block some of the larger or smaller branches of the pulmonary artery. Infarction follows and is indicated by pain, dulness, a rub, and hæmoptysis. In grave cases nothing does any good, but the administration of oxygen and strychnine should always be tried and may tide the patient over his difficulties in some cases of incomplete obstruction. In a few cases the embolus has been removed from the pulmonary artery, but not as yet with any permanent success. The best known way to prevent pulmonary embolism is to adopt the precautions against thrombosis which have already been mentioned.

Some Notes on Surgery in America.

2. The Mayo Clinic, Rochester, Minnesota.

BY E. G. SCHLESINGER.

ROCHESTER has a fixed population of about 8,000 people, and yet over 80,000 patients have been treated at the Mayo Clinic during the past five years. This alone is sufficiently surprising, but still more remarkable is the fact that this great organization has been built up out of a small country practice by two men within the space of twenty-three years. To this great success three factors seem to have contributed, chiefly the remarkable personality and the great surgical ability of Drs. W. J. and C. H. Mayo; secondly, the fact that the patients are treated with scrupulous honesty, and fees are graduated according to the work done and in proportion to the means of the patient, and lastly, because, by constant travel and by acquiring the most highly skilled assistants in the various branches of diagnosis and treatment, their patients are assured that the treatment they receive will be as thorough and as up to date as modern science can make it.

One of the specialties of this clinic is goitre in its various forms, and a great deal of valuable work has been done here on the subject. Dr. Plummer from the clinical aspect and Dr. Wilson from the pathological side, have established very definite relations between the symptomatic and histological aspects of the condition, particularly in the case of exophthalmic goitre. Dr. Plummer holds that exophthalmic goitre runs a fairly regular course, and states that if the average course of the disease be represented by a curve, the greatest height of the intoxication is found to be reached during the latter half of the first year, and that it then rapidly drops to the twelfth month. In many instances it reaches the normal base line during the next six months, more often it fluctuates with periods of exacerbation for the next two or four years. Secondary symptoms and exophthalmos may remain, but the active course rarely continues over four years without distinct intermissions. The ascent may be gradual, sudden, or unequally marked by secondary curves. Exophthalmos is found to be among the later symptoms and is not relied on to a great extent in diagnosis. Bruits or thrills over the gland are found almost invariably to indicate hyperplasia. Diarrhœa, and especially vomiting, are found to be symptoms of a dangerous intoxication, and in their presence operation is delayed until the period of exacerbation is past. Further, in the presence of severe heart damage, as evidenced by cardiac dilatation and irregularity and inequality of the pulse, operation is delayed and palliative measures are employed until the period of increased activity is past. Again, in the treatment of severe cases, the patients are first submitted to a ligation of the vessels at the upper left pole. The reaction to this is noted, and, if necessary, it is followed by a second ligation and by a partial thyroidectomy some weeks or months later. In this way the operative mortality of this condition has been reduced to between one and two per cent. The technique employed has, as its main feature the preservation of the posterior capsule of the gland, thus ensuring safety to the parathyroids and to the recurrent laryngeal nerves. The gland is freely incised, and at the end of the operation, the capsule, with portions of gland tissue adherent to it, is tightly sewn together, so effectively controlling bleeding. No bad symptoms seem to follow this free incision of the gland substance. Interesting associations have been found to exist between simple and exophthalmic goitre. In the first place, persons with pre-existing goitre are sometimes found to develop hyperthyroidism, corresponding with a pathological picture in which is found changes of solid tissue, loss of colloid and vesicles filled with columnar and cuboidal cells in scattered areas instead of a general hyperplasia and hypertrophy as in ordinary exophthalmic goitre.

Secondly, patients over thirty with an encapsuled adenoma frequently exhibit symptoms closely allied to hyperthyroidism and associated with a degeneration of the adenoma. They show marked myocardial damage, nervousness, which, however, differs somewhat from the true hyperplastic type, and tremor, but they practically never develop exophthalmos. The operative risks in this class of case are, however, quite as serious as in true hyperthyroidism.

In the condition of adenomatosis of the thyroid, consisting of a diffuse multiplication of the embryonic acini, there may be an associated hyperplasia of the contained parenchyma with symptoms of hyperthyroidism. This pathological condition again may explain some of the cases of simple goitre, which later show signs of hyperthyroidism. And lastly, adenoma and hyperplasia may, and frequently do, co-exist in the same gland.

The practice of this clinic is to leave one-sixth of the gland tissue as a minimum, although this is held to be excessive. Only one doubtful case of tetany has occurred among several thousand operations for goitre, a fact which is attributed to the practice of leaving behind the posterior capsule of the gland with the attached parathyroids. It appears probable that some of the difference between the number of cases of exophthalmic goitre seen in this clinic, and in others in the States, as compared with the number seen at Guy's, is explained by the fact that the condition is recognized in its earliest stages, when tachycardia, nervousness, and some fulness of the gland, are the only symptoms of note. That these cases are true cases of hyperthyroidism, is shown by the microscopic picture of hyperplasia found in the thyroid after removal. Mainly, however, the abundance of material rests on the fact that the reputation of the Clinic in the treatment of this disease draws patients from all over the country.

The operative mortality in cases of exophthalmic goitre has been reduced to between 1 and 2 per cent., due largely to a knowledge of the proper time to operate, and the operative means to be adopted. Patients in the

active stages of a crisis, as evidenced by diarrhœa, vomiting, and marked exacerbation of the other symptoms, are never submitted to operation until the active stage is past. Cases, who are within close distance of a crisis, are submitted to a preliminary ligation, the reaction after which decides whether thyroidectomy shall or shall not be performed. Muscular weakness is a symptom of much value, and is tested for by making the patient step on to a stool without the assistance of the hands. In operating for goitre, and, indeed, in all other operations at this clinic, great care is taken to ensure perfect hæmostasis, Dr. Mayo being of opinion, that so-called surgical shock is frequently a polite synonym for hæmorrhage.

Stomach surgery is carried to a high degree of perfection, and in a series of 1,000 cases of cancer of the stomach stbmitted to operation, over 33 per cent. have been found to be removable, the mortality in the series being 7 per cent. Of the patients who survived the operations, 38 per cent. were alive and well after three years; there were 25 per cent. of five-year cures.

The view that cancer is frequently superimposed on ulcer is strongly held here, and Dr. Wilson, from an examination of 218 specimens of carcinoma of the stomach, removed at this clinic, found evidences of a pre-existing simple ulcer in over half the cases. Further, Dr. Graham, with a large experience in the diagnosis of these conditions, states, that in the cases of cancer of the stomach, where the diagnosis is confirmed at operation, a previous history, pointing to the existence of a simple ulcer, can be obtained in over 40 per cent. of the cases. Acting on this opinion, gastric ulcers are removed wherever possible, either by incision, or by a devitalising suture, which animal experiments have shown to be equally effective. Finney's pyloroplasty, with excision of the ulcer, is largely used in cases of pyloric ulcer, where there is evidence of slight food retention, a procedure which seems more logical than gastro-enterostomy in these cases.

Free incisions, making possible a thorough exploration of the abdomen are employed in all abdominal cases, a practice which has brought out some important facts as to the association of diseases of the upper abdomen with lesions in the right iliac fossa. Drs. MacCarty and McGrath have made an examination of 5,000 appendices, removed at operations, and have noted the ratio of cases of partial or complete obliteration of the appendix to cases of disease in the upper abdomen, and have compared this ratio with that found at general autopsies and in operation for appendicitis. The partial or complete obliteration of the appendix, they look upon as evidence of a chronic inflammatory process. These observers do not discuss the etiology of the chronic inflammation, whether it is produced idiopathically, or, according to Lane's view, by the involvement of the appendix in evolutionary bands deposited along lines of stress produced by the dropping of an overloaded cæcum. MacCarty and McGrath found partial or complete obliteration of the appendix in 17 per cent. of 2,549 autopsies. The condition occurred in association with gastric or duodenal ulcer in 26·9 per cent. of cases; in cholecystitis in 50 per cent. of cases, and in cholelithiasis in 44·8 per cent. of cases. In 1,005 cases operated on for appendicitis, partial or complete obliteration of the appendix occurred in 23·5 per cent. of cases. An interesting fact found is that although operations for appendicitis occurred more frequently in males than in females, partial obliteration of the lumen of the appendix occurred more often in females (55·2 per cent. female and 44·3 per cent. males), a fact which agrees with the more frequent occurrence of intestinal stasis and its sequelæ in women than in men. A noteworthy fact is that in the pathological examination of the 5,000 appendices in this series, carcinoma of the appendix was found in 22 cases, being apparently developed, as in the gastric carcinomas derived from simple ulcer, from islets of epithelium, which by the process of obliteration had lost their connection with the remaining mucous surface of the appendix.

In operating on the gall bladder, cholecystectomy is preferred to cholecystostomy in all cases where there is reasonable doubt of the gall bladder being able to recover its normal function. "Strawberry" gall bladders, and gall bladders containing a number of small stones, are invariably resected. Operations on the common duct, and secondary operations on the gall bladder, are performed through Perthes' right angled incision, the rectus being held to its sheath by a few temporary stitches inserted before its division, in order to prevent retraction. After operations on the gall bladder or bile ducts, rectal saline in large quantities is administered, on the assumption that its absorption into the portal circulation will induce a greater flow of more dilute bile, and so flush the liver and its ducts.

Dr. Braasch has charge of the department of genito-urinary diagnosis, and has reduced the diagnosis of renal and ureteral lesions to almost an exact science. Ureteral catheterizations and pyelographs are made under local anæsthesia of the urethra in all cases, excepting in a certain proportion of cases of renal and vesical tuberculosis, when ether is given. In operating on the kidney, the Mayo incision, which consists in freeing the lower border of the thorax by an incision, freely dividing the structures attached to the twelfth rib, is almost universally employed, and gives a very good exposure. In cases of tuberculosis of the kidney, the distal end of the cut ureter is injected with 10 minims of pure carbolic acid, and the wound filled with normal saline solution and closed without drainage. There have been no cases of sinus since the adoption of this practice. For double or persistent single pyelitis, lavage of the pelvis of the kidney, with silver nitrate solution through the ureteral catheter, has given very good results. The phenol in sulphonophthale functional test has been extensively tried, but is found to be of little value, excepting as a measure of the relative functional activities of the two kidneys.

Vaginal hysterectomy is the method of choice in non-malignant cases, and is used, with the cautery, in about 15 per cent. of the cases of carcinoma of the cervix. In bad cases of prolapse, Dr. Mayo has devised a very efficient mode of procedure. Vaginal hysterectomy is performed, and the stumps of the ovarian and uterine arteries respectively are sewn to the outer surface of the wall of the vagina, in front and behind, thus effectively supporting the walls of the bladder and the rectum. Perinæorrhaphy, with careful suture of the muscles, is now performed, and this procedure will be found to produce a long and well supported vagina.

All tissues removed at operations are taken direct to the pathological rooms and an immediate diagnosis is arrived at from examination of frozen sections. These sections are stained for a few minutes with polychrome methylene blue, and are mounted in Brun's glucose medium. In this way a very sharp colour differentiation is obtained, and a little practice rapidly makes the observer familiar with the peculiarities of the stain.

The anæsthetics, given entirely by women, consist, in a vast majority of the cases, of ether by the open drop method. No anæsthetic deaths have occurred since the foundation of the hospital, a fact attributable, in part, to the great skill of the anæsthetists, but, no doubt, very largely due to the willingness of the surgeons here to operate with the lightest possible anæsthesia.

The clinical examination of the patients is very thorough. In all stomach cases a complete gastric analysis is made; the coagulation time of the blood in jaundiced patients is estimated, and the freest use is made of the X-rays in diagnosis. The systematic X-ray examination of patients whose pain is referred to either kidney region has brought to light a very large number of unsuspected renal calculi.

A great deal of importance is attached to the tonsil as a primary source of infection, and all suspicious tonsils are removed. In the adult this is invariably done under local anæsthesia, and a complete enucleation after a method, devised by Dr. Matthews, is employed.

Post-operative cases are kept in bed for a much shorter time than at Guy's; abdominal cases without drainage, usually getting up on the sixth or seventh day, while goitres are usually in bed only for four days. In exploratory laparotomies for inoperable malignant disease, the wound is closed with silk, and the patient is allowed to get up the next day, thus avoiding the too frequent progressive asthenia, and ultimate death to which these cases are liable if kept in bed for two or three weeks.

Extensive pathological and clinical laboratories are attached to the clinic, and a great deal of valuable research work is being done, which is greatly facilitated by the employment of a large staff of clerks to keep in touch with the patients operated on, to index specimens, etc. Every possible facility is given to the visitor for post graduate study, in fact, together with the extreme hospitality, courtesy, and willingness to supply information of all connected with the Mayo Clinic, makes it well worth a visit, which will prove as instructive and profitable as it is enjoyable. A large new building containing examination rooms, X-ray departments, clinical, pathological and experimental laboratories, etc., is at present in the course of construction, under the able supervision of Dr. Plummer. In this building, which has been heavily endowed by the Drs. Mayo, every effort is being made to secure thorough co-operation and systematisation of the various departments, and it should do much to maintain the present position of the clinic as one of the foremost, and most up-to-date centres of surgery in America.

Appointments.

Applications to be made on Forms to be obtained at the Medical School Office, are invited for the following appointments, the duties of which commence on October 1st:—

HOSPITAL.—Surgeon to the Actinotherapeutic Department (1); Senior Medical Radiographer (1); Resident Surgical Officer (1); Chemical Pathologist (1); Morbid Histologist (1); Assistant Surgical Radiographer (1).

MEDICAL SCHOOL.—Medical Registrars (3); Surgical Registrar (1); Obstetric Assistant (1); Ophthalmic Assistants (2); Anæsthetists to the Hospital (5); Anæsthetist to Bright Ward (1); Demonstrator of Operative Surgery (1); Demonstrators of Anatomy (2); Demonstrator of Physiology (1); Demonstrator of Chemistry (1); Demonstrator of Physics (1); Demonstrator of Biology (1); Senior Assistant Bacteriologist (1); Junior Assistant Bacteriologist (1).

DENTAL SCHOOL.—Demonstrators of Practical Dentistry with Charge of Revision Classes (2); Demonstrators of Practical Dentistry with Charge of Probationary Classes (2); Demonstrator of Practical Dentistry with Charge of Extraction Classes (1); Demonstrators of Prosthetic Dentistry (2); Demonstrators of Dental Microscopy (2); Curator of Dental Museum (1); Dental Radiographer (1).

Candidates should send their applications to the Treasurer at the Superintendent's Office, on or before June 1st, 1913.

May 19th, 1913. BY ORDER OF THE TREASURER.

Royal College of Surgeons.

At the Primary Examination for the Fellowship of the Royal College of Surgeons in Anatomy and Physiology, held on May 1st, 2nd, 6th, 7th, 8th, and 9th, one hundred and twenty-four Candidates presented themselves, of whom forty-nine were approved and seventy-five were rejected. The following Guy's men were successful:

Braine, J. F. Carter.
Jones, J. Gaymer.
Petley, C. E.
Purkis, K. N.
Reader, Norbert L. M., M.B., B.S.
Saner, F. D., M.B., B.C.

Naval and Military.

Lieut.-Colonel H. A. Smith, I.M.S., has taken up duty as Officiating Civil Surgeon of Simla West.

Major C. M. Fleury, R.A.M.C., has assumed charge of the Military Hospital, Kowloon, Hong Kong.

Captain L. Hirsch, I.M.S., has been placed permanently at the disposal of the Government of Madras.

Captain C. H. Reinhold, F.R.C.S., I.M.S., has been placed at the disposal of the Government of United Provinces for Officiating Civil Employment.

Acting Surgeon A. M. Henry, R.N., has been appointed to *Victory*, additional for course of instruction at Naval Medical School, Royal Naval College, Greenwich, and Haslar Hospital.

Territorial Force.

Lieut.-Colonel Astley V. Clark, M.D., from 5th Northern General Hospital, R.A.M.C., to be Colonel on appointment as Assistant Director of Medical Services, North Midland Territorial Division, vice R. H. Luce, 10th May, 1913.

Colonel R. H. Luce, M.B., F.R.C.S., V.D., late Assistant Director of Medical Services, North Midland Territorial Division, to be Colonel, 10th May, 1913.

Civil.

C. W. Greene, F.R.C.S., has been appointed Certifying Surgeon under Workshop ond Factory Acts for Chatham District of County of Kent.

H. L. Hopkins, M.B., B.S. Lond., has been appointed Assistant County Medical Officer for Suffolk (West). Appointment to commence September 1st.

J. P. Watkin, M.R.C.S., L.R.C.P., has been appointed District and Workhouse Medical Officer, Romsey Union.

National Association for the Prevention of Infant Mortality and for the Welfare of Infancy.

For the Welfare of Infancy.

Arrangements are now well in hand for the English-speaking Conference on Infant Mortality, to be held at Caxton Hall, Westminster, on August 4th and 5th. It is under the immediate patronage of the King and Queen, and will be presided over by Mr. John Burns. Lady Aberdeen, Mr. Pease, Sir George Newman, and Dr. Arthur Newsholme are among the Chairmen of the various sessions into which the two sections—administrative and medical—are divided. Papers will be read by experts from the United Kingdom, the United States, and the Colonies on many aspects of the following questions:—The responsibility of Central and Local Authorities in the matter of infant and child hygiene; the necessity for special education in infant hygiene; medical milk problems; the administrative control of the milk supply; and ante-natal hygiene. The United States and a large number of Colonial Governments will be officially represented, and the attendance generally promises to be very large. The British Railways and Steamship Companies, with services to the Colonies and to the States have all granted special travelling facilities, particulars of which are set forth in the detailed programme, which may now be obtained from the Secretary of the National Association for the Prevention of Infant Mortality, at 4, Tavistock Square, London, W.C.

The Corporation of Liverpool and Glasgow have each given a donation of £50 towards the expenses of the Conference, that of London has given £25, and many other towns are sending smaller sums in proportion to their population.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—ED., G.H.G.]

Royal Commission on University Education in London.

SIR,—The republication in your columns of Dr. Cameron's letter to the *Times*, under the above heading, indicates that you regard the matter dealt with as of special interest to Guy's men generally. The Dean tells the Editor of the *Times* that he has not in any way consulted his colleagues in the Medical School. This, no doubt, he will shortly do. It is not, however, so easy for him to consult a much larger body of men who are almost equally interested with the Staff, viz., the past and present students of Guy's Hospital. You, Sir, through your columns, could at least secure valuable expressions of opinion from some of your many readers who are being or have been educated at Guy's. Lookers on often see most of the game, and men in practice who have tested during twenty-five years the result of their own professional education, and are now becoming interested in that which their sons are obtaining, may offer useful criticisms upon the suggestions of Lord Haldane's commission and the alternative proposals of the Dean.

The question of the proper direction in which to look for improvement of medical education is an extraordinarily difficult one. Fortunately, however, for the reformers, hardly anyone now will state that medical education cannot be improved. In the hope of encouraging suggestions from other quarters I venture to criticise one point of view attributed by Dr. Cameron to Mr. Flexner, and another for which Dr. Cameron himself is responsible.

It is stated, in the letter you republish, that Mr. Flexner contends that certain arrangements "while admirable for teaching purposes, are ill-suited to encourage research and the advancement of knowledge." I do not know whether Mr. Flexner is fairly represented in this sentence which is not marked as a quotation, and I do not quite understand the distinction, if any, which it may be intended to make between research and advancement of knowledge, but I am prepared strongly to contend that no arrangements can be tolerable, far less admirable, for teaching purposes which do not encourage and promote the advancement of knowledge. In medicine, as indeed in every subject worthy of our study, the only admirable way of teaching is to associate closely the pupil and his teacher in the promotion of advances in knowledge. The teacher and the pupil must, in fact, be fellow learners. It may be possible to cram by other methods, it is impossible to teach and it is certainly impossible to teach admirably.

The other point of view apparently held by Dr. Cameron himself, to which I take exception, is that there is any recent special change in the nature of the Science of Medicine that makes it particularly difficult at the present day for senior men to advance our knowledge, or particularly necessary that their duty should be entrusted to junior men.

The greatest advances in knowledge have nearly always been actually made by men in the earlier half of life, and if the senior men doing clinical work do not continue to promote their science so vigorously as do the senior teachers of, say, Physiology and Chemistry in this country, or the senior teachers of clinical subjects on the Continent, it is not because their science is peculiar or their senility more rapidly reached, but because their association with their juniors in carrying out their duties is far less intimate than is the case with the other classes of teachers cited. The University professor on any scientific subject in this country, and the Professor of Medicine or Surgery on the Continent, is constantly surrounded by his Demonstrators or Assistants, who share with him the responsibility of advancing knowledge and training the pupils. The Surgeon or Physician in our Medical Schools has an assistant only in name, and pathetically struggles single handed at the impossible task of doing his duty to his science, his patients, and his pupils.

Those who hope to see Guy's taking a foremost place in evolving a better system of Medical Education should urge on Deans and others responsible the desirability of linking together in organised interdependence for the advancement of medical knowledge the entire population of the Medical School from the most senior consulting officer to the youngest ward clerk.

It will be fatal to our prestige as an Educational Establishment if we set our fossils admirably to teach and seclude our best young brains to "Research with a capital R.—I am, Yours etc.,

17th May, 1913. ONCE A JUNIOR.

Shingles and Chicken-pox.

DEAR SIR,—In reference to the article and letters concerning "Shingles and Chicken-pox," perhaps the following may hold interest for you:—

My nephew, a boy of thirteen, was exposed to infection from Chicken-pox at school, and during the recent Easter holiday, spent at his home, was considered more or less in quarantine. Two and a half weeks after he was last exposed to infection, he developed Shingles. Although a healthy boy, he has usually taken any infection to which he was exposed, and has not previously had Chicken-pox. In this case the sequence has occurred in the reverse direction to those quoted by your correspondents whose letters are published in the GAZETTE of May 10th, and who mention Chicken-pox as being developed after the shingles' patients had recovered. —I am, yours sincerely, "A member of the G.H.N.L."

May 14th.

Guy's Hospital Musical Society.

THIS Society gave its second Concert of the season on the evening of May 6th, Mr. Denis-Browne conducting for the first time. The Society is to be congratulated on the re-appearance of the orchestra, and on this account, perhaps, one should forego stern criticism; it was very evident, however, that the orchestra had "tuned up" to the old piano used for rehearsals, and Mr. Stirling-Hill's accompaniment on the Grande Bechstein, provided for the occasion, gave the direct lie to their intonation. Apart from this unfortunate mistake, the orchestra rendered their pieces well; they showed best in Schubert's "Ballet Music from Rosammide"; it is interesting to note, Ives' "Covanto" had not been played for 250 years.

The chorus was not heard at its best, although no one could have worked harder than Mr. Denis-Browne; his enthusiasm and labour has been conspicuous throughout, but it was impossible for him to do justice to the music with such a small number of male voices; Mr. Clive Carey's solo work in Stanford's "Songs of the Fleet" was a masterpiece, and one felt instinctively that his presence was a great help to the chorus. When all worked so hard, it would be invidious to make comparisons, nevertheless, the soloists of the programme lay fair claim to be the success of the evening.

Miss Hinds again treated the audience to two excellent songs, her clear articulation and phrasing being conspicuous. Nurse Drower was evidently nervous, but she sang a difficult song with commendable effect. Mr. Denis-Browne showed his genius as a pianist, and one could not wish to hear a finer rendering of Chopin's Polonaise in C sharp minor than his. Mr. Clive Carey sang two old English folk songs, in his own inimitable fashion—his own arrangement of "The Lily" being particularly effective.

Mr. Thompson's fine baritone voice was heard at its best in Moore's "She is far from the Land," and he is to be congratulated on the great improvement his voice has made since his previous appearance on the concert platform in December, 1911. Last, but in nowise least, one was struck by the excellence of Mr. Stirling-Hill's accompanying; his work at the piano showed an accurate technique, and an intimate knowledge of that "response" to the vocalist, so essential to the success of an accompanist. One hopes to see more of this musician's abilities in the future.

International Dental Congress, 1914.

THE Sixth International Dental Congress will be held in London from August 3rd to 8th, 1914, at the invitation of the British Dental Association.

His Majesty King George V. has graciously consented to be the Patron of the Congress, which will take place

at the University of London, and at the Imperial College of Science and Technology, South Kensington.

The President of the Congress will be Mr. J. Howard Mummery, and the joint General Secretaries are Mr. Norman G. Bennett and Mr. H. R. F. Brooks. Mr. H. Baldwin is Hon. Treasurer.

A Committee of Organization, under the Presidency of Mr. W. B. Paterson (President of the International Dental Federation), with Mr. F. J. Pearce as Hon. Secretary, has been busily engaged for some time in making the preliminary arrangements.

Previous Congresses have taken place in Paris, 1889; Chicago, 1893; Paris, 1900; St. Louis, 1904; and on the last occasion at Berlin, in the Reichstag, in 1909, when the German Emperor took a personal interest in the meeting; delegates attended from twenty different countries, and the Governments of many of them were officially represented.

Invitations are being issued to Dental Organizations throughout the world, and it is hoped thus to secure the co-operation of leading specialists and representative authorities in all branches of dental surgery.

The Rules of the International Dental Congress provide that all ethical practitioners of dentistry possessing the qualification of the country in which they received their professional education, or of the country in which they practice, are eligible for membership.

The Subscription for members of the Congress will be 30s. (38 francs; 31 marks; 7½ dollars), and for members of their families accompanying them 15s. (19 francs; 15½ marks; 3¾ dollars).

The Offices of the Congress are:—19, Hanover Square, London, W., to which address all communications should be sent.

Golf.

THE STUDENTS v. THE STAFF.

This match was played on Wednesday, April 23rd, at Sundridge Park under ideal conditions and ended in a victory for the Students by the narrow margin of two points. Unfortunately both sides were not fully represented, the absentees including Dr. Cameron, Mr. L. M. Bromley, L. A. Graham, and F. A. Knott. Score:

SINGLES.

STUDENTS. STAFF.

M. B. Tweed, ½, Dr. Pitt, ½.
W. E. Tanner, 0, lost to Mr. F. J. Steward, 1 (4 and 2).
C. Dean (6 and 5), 1, beat Mr. Rowlands, 0.
W. E. S. Digby, 0, lost to Mr. E. C. Hughes, 1 (5 and 4).
O. Morgan (3 and 1), 1, beat Mr. Mollison, 0.
R. A. Fawcus (4 and 3), 1, beat Mr. R. Davies-Colley, 0.
F. G. L. Scott (5 and 4), 1 beat Dr. Ryffell, 0.
C. Lambrinudi, 0, lost to Mr. H. Lee, 1 (5 and 4).
J. F. Venables (5 and 4), 1, beat Mr. J. G. Saner, 0.
R. Curle, ½, Mr. G. H. Hunt, ½.
Totals: Students, 6; Staff, 4.

FOURSOMES.

M. B. Tweed and R. A. Fawcus, 0, lost to Dr. Pitt and Mr. Davies-Colley (1 up), 1.

R. Curle and W. E. Tanner, 0, lost to Mr. Hunt and Mr. Steward (3 and 2), 1.

C. Dean and F. G. L. Scott (6 and 5), 1, beat Mr. Rowlands and Dr. Ryffell, 0.

W. E. S. Digby and J. F. Venables (3 and 2), 1, beat Mr. Hughes and Mr. Saner, 0.

O. Morgan and C. Lambrinudi, ½, Mr. Mollison and Mr. H. Lee, ½.

Totals: Students, 2½; Staff, 2½.

GUY'S v. ST. THOMAS'S.

FINAL INTER-HOSPITAL CUP, 1912.

This match was played at Sundridge Park on Friday, April 25th, and resulted in a victory for St. Thomas's by 8¼ points to 1. Although we were not fully represented we were beaten easily by a much superior team to ours, C. Gardner Hill going round in the remarkably good score of 73, the bogey for the course being 78. Result:

GUY'S. ST. THOMAS'S.

R. A. Fawcus, 0, lost to C. Gardner Hill, (8 and 7), 1¼.
F. G. L. Scott, 0, lost to Dr. Corbett (7 and 6), 1¼.
R. Curle, 0, lost to P. Verdon (3 and 2), 1.
O. Morgan, 0, lost to K. Neilson (4 and 3), 1.
J. F. Venables, 0, lost to L. W. Shelley (6 and 4), 1¼.
C. Lambrinudi (4 and 3), 1, beat H. C. Attwood, ¼.
R. L. Creasy, 0, lost to E. Wordley (5 and 3), 1¼.
W. E. Tanner, 0, lost to H. T. Walker (1 up), 1.
Totals: Guy's, 1; St. Thomas's, 8¼.

Births.

IRVINE.—On May 17th, 1913, at Beechwood, Chesham Bois, Bucks, to L. C. Dundas Irvine, B.A., M.R.C.S., and Mrs. Irvine (née Prescott), a daughter.

MUNDEN.—On May 10th, 1913, the wife of M. Mintern Munden of Wickham Grange, Chalford, Glos., of a son.

Marriage.

DRUITT—BEADEL.—On April 30th, at S. Peter's Church, Bexhill-on-Sea, Daniel Cuthbert Druitt, M.R.C.S., L.R.C.P., to Evelyn Mary, younger daughter of Mr. Charles Beadel (and the late Mrs. Beadel), of Hillside, Bexhill-on-Sea.

Death.

BARLOW.—On May 10th, 1913, at 88, Dalston Lane, N.E., Thomas Carey Barlow, L.R.C.P. and L.M., L.R.C.S., L.S.A., aged 60.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette." Guy's Hospital, London, S.E.*

Ed.—G. T. M.

GUY'S HOSPITAL GAZETTE.

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The School's Progress and its Need.

WHEN Thomas Guy made the Will which became the Constitution of his Hospital, and provided for the subsequent appointment of those original two Physicians and two Surgeons, whose emoluments at the same rate of £40 per annum are still, we believe, enjoyed by present senior members of our professional Staff, he may have had a vision of the great Medical School that was to form the complement of his desire. But whatever the foresight or intention of the Founder may have been, it is certain that whereas his act in effect founded the School with the Hospital, he made no special provision for its support; consequently, yet with readiness on the part of its members and as an acknowledgment of reciprocal benefit, the Medical School has to the present day paid for itself, beyond those generous gifts for specific objects which are in recent and grateful memory. Since 1724 many tides have ebbed and flowed under the arches of our friendly neighbour, London Bridge, and in all the years the search in the Street of St. Thomas for the knowledge of healing has been as regular and persistent as those tides. In this column it is needless to recite familiar and honoured names, or to tell the tale of the results obtained; results, that from a financial standpoint it is an inevitable misfortune should be unknown to the world, yet of which mankind from the highest to the lowest are alike beneficiaries and equally concerned in the story of devoted service, patient endeavour and self-sacrifice in all things that might save man's body or ease his pain, which reached an epoch on Tuesday last, when Mr. Balfour formally opened the completed New Buildings of the Medical and Dental Schools.

On behalf of Guy's men, those at home, and those many true workers scattered over the face of the earth, we sincerely thank Mr. Balfour for what he said, and even more, for the way in which it was said. The tone and depth of his appeal, we humbly venture to say, is the best guarantee that the present need of the School will soon be met; that the £17,000, already unobtrusively contributed as the result of a private appeal within the present year, will be supplemented by the £23,000 required to free Guy's Hospital Medical School from its first debt; thus discharging the outstanding balance of an outlay which has given the School complete space and equipment. And we hope further that the £200,000 required to justify the retention and the maintenance of the quiet but great man; the man who can not only do, but explain; the man who can investigate; the man possessed of that kind of originality which makes Nature yield her secrets, will not be long withheld. We are using Mr. Balfour's thoughts, and continue them. "All that organisation could do was to give to those rarely-endowed individuals some opportunity by which they could effectively exercise for the common advantage the gifts which God had given them." For these words we again thank Mr. Balfour.

Yet, when all is said and done, there is, as proved by experience, no truer or more effective source of help than the help which comes through the men who in past times have paced the Colonnade; the men who know. We do not distinguish between the Consultant and the General Practitioner. The former may have the greater opportunity, the latter, we know full well, has not, in these times, if ever, dwelt in a land of plenty, comfort, or security; but he has his rewards for a life of hard toil with little personal gain, and of these rewards perhaps the chief is the privilege and the power of righteous influence on others which, with Guy's men, is a living tradition.

Passim.

THE ceremony in the Physiological Theatre on June 3rd, when Mr. Balfour formally declared the new School Buildings open, will for many years to come form a prominent landmark in the history of the Medical School. It represented the culmination of that great scheme of rebuilding which commenced in 1897, and has since progressed as fast as the funds available would allow to its completion —a scheme which has included nearly every single department in its comprehensive scope, and which has entirely transformed the School. Guy's men who remember the difficulties and disabilities under which former generations of men worked—the over-crowded, ill-equipped laboratories, the uncomfortable theatres hardly equipped at all, according to our more luxurious and exacting ideas—may well be proud of a School which in a few short years has, partly, indeed, by the generous help of benefactors, but mainly by its own exertions and sacrifices, transformed itself into an institution, equipped with theatres and laboratories, second to none and superior to most. And all this, it is important to note, has been done without adding at all to the already heavy burden of fees which the medical student must bear, and without any money being diverted from the funds of the Hospital itself.

It is, indeed, a proud record for any school, and one which shows that that spirit which animated Thomas Guy, our Founder, and Hunt, our second Founder, which nearly twenty years ago transformed and rehabilitated the Hospital, still lives on among Guy's men, and will, we believe, continue to live and thrive as long as hospitals and medical schools exist—that spirit which unites all Guy's men into one great bond of fellowship all over the world, and which keeps our alma mater and her alumni prepared to meet with courage and equanimity all those trials and tribulations which the future may hold for her and them.

HAVING patted ourselves on the back and said what fine fellows we are, it must not be thought that we are now in a position to sit down and admire ourselves for the rest of time. No, the rebuilding of the School was only a gentle foot hill, which must be ascended before we were in a position to start our real work—to climb those far more arduous heights which must be surmounted before we can say that we are finished. As Mr. Balfour pointed out on Tuesday, we are not yet in a position to say "we now will look back upon the work that has been done, congratulate ourselves upon its success, and rest from our labours"—rather must we say we have only begun. We are now in a position to give all our attention to the great work of Endowment of the School, a task more expensive, and probably more arduous than the Rebuilding, but one which we believe the energy and courage of Guy's men is quite as capable of carrying out to a successful completion. That it is an undertaking essential for the future of the School is, we believe, self evident to all Guy's men, and Mr. Balfour's speech emphasises clearly that now is the time for action. The GAZETTE promises in its own name, and equally confidently in the name of its readers, a cordial co-operation in any scheme which the School Authorities may put forward in furtherance of this great object.

OUR very hearty congratulations to Sir William Arbuthnot Lane, Bart., whose name appears in the Birthday Honours List. "Willie," as we all know, fully deserved the honour, and we wish him a long and prosperous life in which to enjoy it, and to shed further lustre on the Hospital and the Profession.

WE hear with much pleasure that Mr. S. W. Daw, F.R.C.S., has been appointed Assistant Surgeon to the General Infirmary, Leeds. Mr. Daw was Resident Surgical Officer here in 1908–9, succeeding Mr. E. C. Hughes, and then left us to take up a somewhat similar post at Leeds, where he has remained. We wish him every success.

CONGRATULATIONS to Mr. A. H. Todd on obtaining the Fellowship of the Royal College

of Surgeons. Mr. Todd's achievement is all the more praiseworthy in that he is still a Resident, being at present Ophthalmic House Surgeon. It is, we believe, a good many years since a Resident last gained the Fellowship.

WE hear with great regret that Sister Lydia (Miss F. A. Sheldon) is leaving Lydia ward to take up the duties of Lady Superintendent of the Trained Nurses' Institution, vacant by the resignation of Miss H. H. Strick (Sister Clinical, 1901–1908). It is a constant source of regret to us that practically all the higher posts in the nursing profession are distinguished as administrative, and not as nursing posts. It seems such a pity that those women who have especially distinguished themselves as nurses, should be suddenly cut off, to all intents and purposes, from their patients. Miss Sheldon carries with her, we feel sure, the good wishes of those nurses and men, and their number must be great, who have felt themselves shamed, and at the same time encouraged by her whole-hearted enthusiasm and sympathy.

LAST year an appeal was made to Guy's Dental Men for money to purchase new and modern chairs for the Conservation Room. The response to this appeal was £326 5s. 3d., less than one-third of the total sum, £1,150, expended on new chairs alone in the Conservation Room. A further earnest appeal is made to all who are interested in the Hospital, and especially to past dental men to contribute to the fund, which will be closed at the end of the Summer Session.

OUR readers will be glad to know that Mr. Wingent's book: "The Borough and the Borough Hospitals," the substance of which originally appeared in the GAZETTE under the title of "London Bridge and the Borough in the 18th Century," is now published in book form, at the very moderate price of 3s. to Subscribers. Subscriptions, which should be sent to the Manager of the GAZETTE, should be sent in before July 1st, as after that date the price will advance to 3s. 6d.

Obituary.

JAMES HENRY TARGETT, M.S., F.R.C.S.

WE very much regret to have to announce the death of Mr. Targett, after a long and lingering illness. Mr. Targett, who was 51 years of age, was Obstetric Physician, first as Assistant and later as Full Physician to the Hospital since 1898. He will be keenly missed by all who have worked under him or come into contact with him in the hospital, not only as a great teacher, but still more for his charming and gentle personality. The Hospital and School sustain a severe blow in the loss of an Obstetrician and Pathologist of the eminence to which Mr. Targett had so justly attained.

We offer our very sincere condolences to Mrs. Targett and his relatives.

We hope to publish an appreciation of Mr. Targett as a man and a teacher by one who knew him well, in our next issue.

Pass List.

University of Cambridge.

The following Degree has been conferred:—

M.B.—T. N. Wood, B.C.

University of London.

THIRD (M.B., B.S.) EXAMINATION FOR MEDICAL DEGREES, MAY, 1913.

HONOURS.

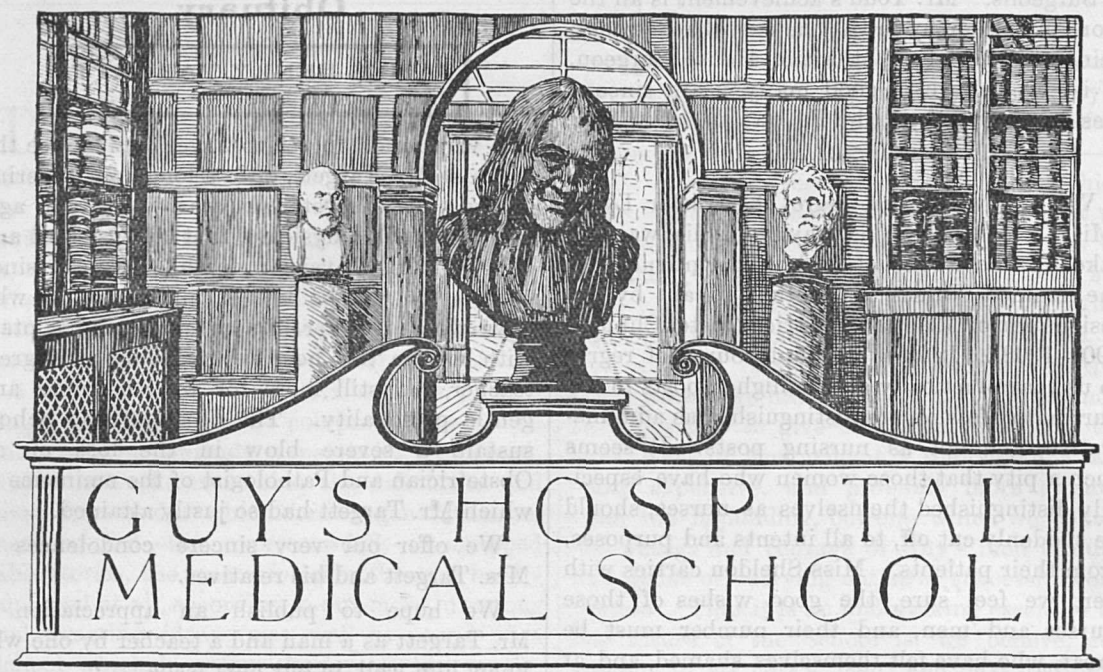
W. L. Webb: Distinguished in Pathology.

PASS.

Covell, G.	Killpack, C. D.
Edmond, J. A.	Miller, G. S.
FitzMaurice, A. L.	Robinson, W.
Foster-Smith, G. T.	Ryle, J. A.
Keith, S.	Smith, A. J. E.

Society of Apothecaries.

The Diploma of the Society has been granted to Mr. E. L. Jones, entitling him to practise Medicine, Surgery, and Midwifery.



Opening of the New School Buildings

BY

The Right Hon. A. J. BALFOUR, M.P.

THE Festival which marked the completion of the scheme of rebuilding commenced in 1898 was celebrated on Tuesday, June 3rd. The whole affair was an unqualified success from beginning to end. The weather was perfect, it being a bright sunny day such as we get all too seldom at functions of this kind. The arrangements were all so well managed, thanks to the forethought and trouble of the authorities, that not a hitch occurred, and finally, last, but by no manner of means do we mean to insinuate least, the speeches were magnificent. Altogether we feel that those who organised the fête have every reason to be pleased with themselves, and have only now to wait and see what material results will be forthcoming for their trouble.

The meeting in the Physiological Theatre was preceded by a luncheon in the Court Room to which the School invited Mr. Balfour and a large and distinguished company.

After lunch the party, headed by Mr. Balfour, the Treasurer, Lord Goschen, and the President, Mr. Cosmo Bonsor, proceeded across the Park to the Physiological Theatre. The leaders of the procession, if we may judge from the remarks we overheard, greatly distressed the Press photographers, who were lying in wait for them, by turning round just at the critical moment.

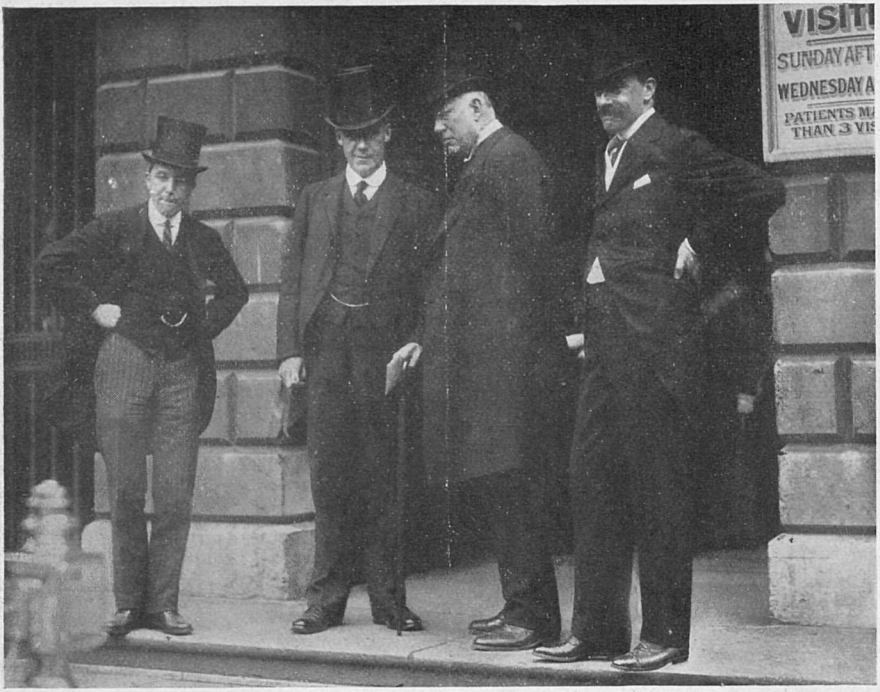
The Theatre was filled to overflowing with guests of the School and Governors, amongst those present being :—

Lord Aldenham, Sir Clifford Allbutt, Sir Thomas Barlow, Mr. J. H. Binyon, the Rev. Dr. Barber (headmaster of Leys School, Cambridge), Mr. Otto Beit, the Hon. John Biddulph, Mr. H. C. O. Bonsor, Dr. A. E. Boycott, Mr. R. M. Burrows (principal of King's College), Sir Edward Busk. Dr. H. C. Cameron, Sir William Collins, Professor Cushny, Dr. H. H. Dale, Mr. Frank Debenham, Professor W. E. Dixon, Dr. Gordon Douglas, Professor Georges Dreyer, Dr. T. Gregory Foster (Provost of University College), Sir Alfred Fripp, Lord Goschen, the Rev. Dr. Gow (headmaster of Westminster), Sir Cameron Gull, Mr. P. L. Hall, Mr. F. G. Hallett (secretary of the Conjoint

Opening of New School Buildings, June 3rd, 1913.

Mr. Balfour and Dr. Hale White.

In the Park.

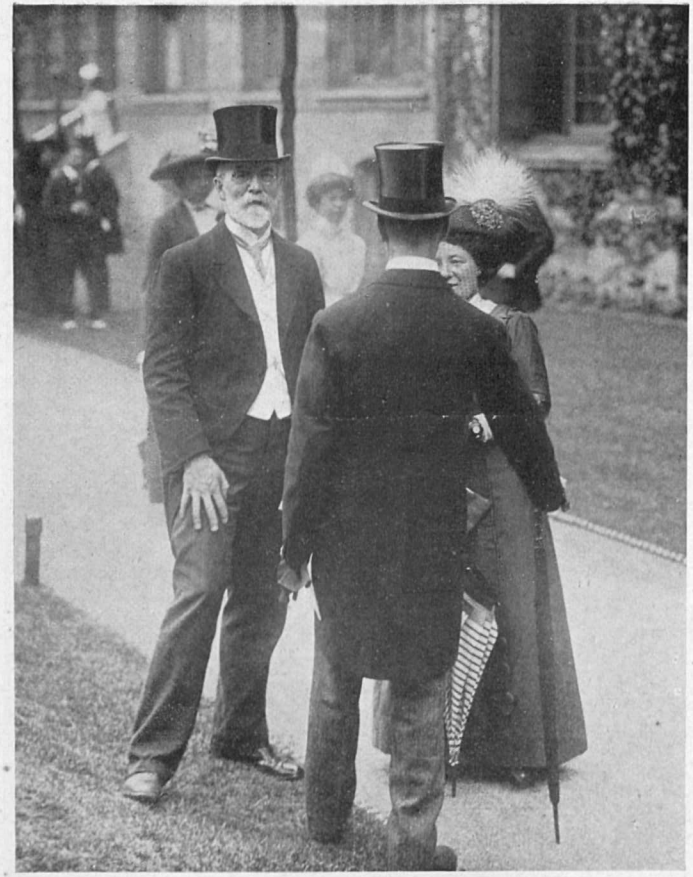


On the Colonnade Steps.

Dr. Newton Pitt.

In the Theatre.

In the Park.



"CHARTERS."

OUR NEW BARONET.

Board), General Sir Richard Harrison, Mr. C. L. S. Hatton (principal of East London College), Dr. W. P. Herringham (Vice-Chancellor of London University), the Rev. Dr. Hillard (headmaster of St. Paul's), Professor Arthur Keith, Professor Langley, Dr. Graham Little, Mr. W. Loring (Warden of Goldsmiths' College), Professor A. Macalister, the Hon. Thomas MacKenzie (High Commissioner for New Zealand), Sir Philip Magnus, M.P., Mr. F. B. Malins (headmaster of Haileybury), Sir Henry Miers (principal of the University of London), Mr. J. H. Mummery, the Rev. Dr. Nairn (headmaster of Merchant Taylors), Professor Poulton, Lord Revelstoke, Mr. W. G. Rushbrooke (headmaster of St. Olave's), the Rev. Dr. Scott, Colonel B. M. Skinner, Mr. Nowell Smith (headmaster of Sherborne), Sir Richard Solomon, Dr. H. J. Spenser (headmaster of University College School), Professor Starling, Dr. W. B. Taylor (master of the Apothecaries), Mr. Vincent Vickers, Mr. F. B. Vincent, the Rev. H. Costley White (headmaster of Bradfield), Dr. W. Hale White, Mr. C. D. Whittaker, Mr. J. H. Widdicombe, Mr. F. J. Wylie, Sir John Broadbent, Sir W. Dunn, Sir James Goodhart, Sir Henry Howse, and Sir George Turner.

And the gallery was packed with students who gave Mr. Balfour and the Treasurer an ovation on their appearance. As soon as everybody was settled comfortably, Viscount Goschen opened the proceedings in a short but very telling speech, in which he sketched briefly the circumstances in which the School had been re-built, laying particular stress upon the debt which is due both to outside benefactors and also to the Hospital Staff, both individually and collectively. He congratulated Mr. Lane in the name of all those in or of the Hospital, and of all those interested in the Hospital on the honour which the King had just conferred upon him. He then called upon Mr. Balfour, not only as a statesman, not only as a Governor, but also as one keenly interested in the progress of science to declare the new buildings open.

Mr. Balfour, who on rising received a great ovation, then spoke for about twenty minutes, delivering a speech which may be truly described, as Dr. Hale White said later, as one of the greatest ever delivered upon the subject of the Endowment of Medical Research. A full report of the speeches will be found elsewhere in our columns, and Mr. Balfour's words will be found worthy of very careful perusal, and still more of practical application.

He recalled, that on his previous visit to the Hospital in 1898, he had emphasised the need for research in what he happily called the "greatest of all the practical professions." This phrase provides us in a nutshell with the ground upon which to take our stand in the ever recurring argument, as to the comparative status, moral and intellectual, of the various learned professions. He pointed out, that by having rebuilt our School buildings we have not finished our work, in fact that we have only started. Now we must proceed to find both the men and the money to keep these chosen men at work. Then speaking more directly to the lay public, he pointed out in telling lauguage, how the responsibility for this provision of money for the endowment of research lay with them, emphasising the fact, so well known to us all, that the necessity for the endowment of research, although less obvious and less spectacular than the need for the direct endowment of hospital beds, if medicine in England is to keep that foremost place it now holds among the great nations of the world. He described the rivalry of nations in the pursuit of knowledge as being as great as, if happier than, their rivalry in armaments—and almost as expensive—a phrase which brought down the house. At the close of his speech Mr. Balfour received another, and heartier ovation.

Viscount Goschen then called upon Dr. Hale White to move a vote of thanks to Mr. Balfour, which he did in a very able speech in which he gave details as to the money required for the endowment of the school.

Sir Arbuthnot Lane, who received tremendous applause in recognition of the baronetcy conferred upon him, in a short but characteristic speech, in which he appealed in contra-distinction to Mr. Balfour and Dr. Hale White to the heads and not the pockets of his audience, seconded the motion, which was the occasion for another outburst of cheering for Mr. Balfour.

The proceedings then terminated, and the assembled guests proceeded to inspect the New Buildings.

The Garden Party.

After the ceremony in the Physiological Theatre the Annual Garden Party was held, and, in addition, the new Chemical and Physics Laboratories, the new Pathological Department, and the new Conservation Room, the rest of the Medical School Buildings and the wards and departments of the Hospital itself were thrown open for inspection. The function was one of the most successful held in recent years, the clerk of the weather being in particularly festive mood, and providing us with perfect weather, so

that the grounds looked their best, and our cousins and our aunts were emboldened to visit us in all their brightest and most gorgeous raiment. The scene in the Park was kaleidoscopic in the multitude and variety of the colours displayed. On all hands, however, we heard regrets expressed that no academic costume was worn, the general feeling being apparently that whilst individuals may have been gainers the function lost both in dignity and in interest through its absence. We feel sure that in future years the authorities would be wise in reviving its general use.

As on previous occasions many mere males availed themselves of the opportunity for a peep inside the Nurses' Home, and also, as usual, we detected several lilac uniforms inside the sacred portals of the College.

It was noticeable how many more of our visitors inspected the School Buildings than in previous years. This was partly due, no doubt, to the fact that the excuse for the Garden Party was their formal opening, but much more to the very interesting demonstrations of their activities which the various departments gave. The exhibits in the Biological Department, which must have meant an immense amount of labour on the part of those responsible, were particularly popular. We noted with much pleasure, as evidence of a keen and healthy spirit of life in the department, that several of these exhibits were got up by individual students. Tea was served for the visitors in the Nurses' Colonnade and in a large marquee in one of the quadrangles of the Surgical Buildings. The music, which was very excellent, was provided by the Royal Meister Orchestra.

The following demonstrations were given :

A.—In the Biological Department.
By Mr. Assheton.

1. Living Bird and Fish Embryos.
By Mr. Assheton, Mr. Mullally, and Mr. Mayer.
2. Methods of Embryological Research.
3. Mammalian Eggs.
By Mr. W. H. Steavenson.
4. Pond Life.
By Mr. Read.
5. Plant movement and Research Work in Botany.
6. The Food of Plants.
By Mr. H. G. Berncastle.
7. Collection of Mammalian Brains.
By Mr. and Mrs. Reed.
8. Form and Structure of Plants in Relation to Environment.
By Mr. and Mrs. Assheton.
9. Form and Structure of Insects in Relation to Environment.
10. Marine Animals.

B.—In the Pathological Department.

1. Demonstration of the Epidiascope.
2. Demonstration of Photo-micrography.
3. Demonstration of Pathogenic Bacteria and of the application of Bacteriology to the Diagnosis and Treatment of Disease. By Dr. Eyre.
4. Methods of Histological Research.
5. Demonstration of Bacteria by Dark Ground Illumination.
6. Demonstration of the kymograph by the Graphic Record of the Contraction of Muscle. By Dr. Mutch.
7. Methods of Sterilisation.

C.—In the Department of Physics.
By Mr. Abrams.

1. Demonstration of Geissler Tubes and X-rays.
2. Demonstration of Westinghouse Mercury Arc Lamp.

D.—In the Department of Chemistry and Public Health.

1. Methods of Water Analysis and other aspects of Sanitary Science. By Mr. Rogerson.
2. Demonstration of the Wade and Merriman Manostat and Compressor. By Mr. Merriman.

The Formal Opening of the New School Buildings

BY THE

RIGHT HON. ARTHUR J. BALFOUR, M.P.

A VERY large and distinguished company were present in the Physiological Theatre on Tuesday, June 3rd, under the chairmanship of Viscount Goschen, to welcome the Right Hon. Arthur J. Balfour, who had kindly consented to declare the new School Buildings open. There were also present most of the members of the Staff, including the new Baronet, Sir Arbuthnot Lane.

VISCOUNT GOSCHEN : Mr. Balfour, my Lords, Ladies and Gentlemen. We are celebrating to-day the completion of the new buildings of our School, and it is my privilege to ask Mr. Balfour to declare them completed to-day. I am sure that in our opinion there is no one more fitting to do so than Mr. Balfour. (Applause). I should like to assure him, in the name of those who are gathered here to-day, that we welcome him, not only as a great Statesman whose services to the country have won the admiration of all sections in the land—(applause)—not only as one closely connected with Guy's as a Governor, but especially to-day as a disciple of science, and as one who has enthusiastically supported the scheme which has resulted in the completion of these new buildings. (Applause). In fact, I am sure I may say that a great deal of the success of the enterprise is due to the

encouragement and inspiration which he gave to us when he delivered an address here on the occasion of the prize-giving in 1898, the motive of which address I think I may say, quoting his own words, was that he was an ardent believer in the cause of the endowment of research. And on that occasion he made an eloquent appeal for that cause, which contributed greatly to our success in completing these buildings. Ladies and gentlemen, there have been two historic occasions connected with the building of our School. The first, I think I may say, was in 1893, when Mr. Gladstone, who was then the oldest of our Governors, opened the Students' College, naturally a preliminary step to the building of our School. The second was in 1897, when his late Majesty King Edward opened a portion of these buildings, which now belong to the department of physiology. On that occasion King Edward, who was then President of the Hospital, alluded to the fact that he regarded the opening of these buildings only as an instalment of a much larger scheme. And he expressed the hope then, that the completion of the buildings might soon be accomplished, and that, when they were, there might be an adequate, and proper accommodation for those wax models which had so greatly interested him when he had visited the museum. I think I may say, that had his Majesty lived till to-day, he would have been greatly gratified to see the fulfilment of the wishes which he expressed on that occasion. (Applause). Guy's Hospital owes a deep debt of gratitude to King Edward. He was always an enthusiatic and generous supporter of the Hospital, and took the deepest interest in all that concerned it, an interest which I am sure we are proud to think has been handed down to his son, King George—(applause)—who has to-day given a proof of the interest which he takes in the Hospital by the honour which he has conferred upon Mr. Lane—(loud and prolonged applause)—to whom in the name of all in the Hospital, and connected with the Hospital, and all those having an interest in the Hospital, I desire to offer most hearty congratulations. (Renewed applause.) Ladies and gentlemen, the third interesting occasion in the history of these buildings has arrived to-day, when Mr. Balfour will declare the completion of these buildings accomplished, and I am sure you will agree with me that we find in him a worthy successor of those who have been associated with the history of these buildings in the past, and I think that it is a great privilege to us to reflect that on every occasion when a ceremony was to be undertaken by these famous men, they looked upon it in no perfunctory spirit, but it has been performed, as it will I am sure be performed by Mr. Balfour to-day, by those who have been closely associated with Guy's and who have been inspired by a personal and intellectual interest in its work. I am going to say but one word upon this somewhat dull subject of finance, but I should like to say that these buildings have been erected at considerable cost, but that not one single pennypiece that has been provided for them has been provided out of the funds of the Hospital. (Applause.) And the Governors owe a deep debt of gratitude to their friends on the staff and to the friends off the staff who have so generously come forward and assisted us in completing these buildings. (Applause.) I am sure that I may say for the Governors that we realise that a great heritage has been handed down to us by famous men connected with Guy's in the past who have made the name of Guy's what it is to-day; and we also feel that we have a great trust for the future, a trust to provide for the rising generation adequate means for obtaining the knowledge to fit them to take their place in the great profession which never stands still but always moves forward to higher things. (Hear, hear.) As it progresses so must we progress, and we do not regard the completion of these buildings as a resting place, but we shall go forward, I hope, with courage and with confidence to endeavour so to endow them as to obtain the best value for them, and in this work we shall be encouraged and inspired by the support and assistance which we have all along been given by friends of our's such as Mr. Balfour, who I will now ask to declare these buildings open. (Loud cheers.)

The Rt. Hon. A. J. BALFOUR, M.P., who was most cordially received on rising, said: Lord Goschen, Ladies and Gentlemen,—Your Chairman has reminded you that some fifteen years ago I had the pleasure and the honour of speaking in this hall to the predecessors of the present students upon the claims which research had and must have upon all who desire to see this country maintain its place among the nations of the world in what is, after all, the greatest of the practical professions. In the fifteen years that have elapsed since then this great block of buildings, which it will be my privilege to declare open at the conclusion of what I have to say, has been entirely, or almost entirely, constructed. £100,000 has been spent so far, and you might at first be disposed to say we can now look back upon the work which has been done and congratulate ourselves upon its success and rest from our labours. Ladies and gentlemen, that is not the spirit in which I am going to address you this afternoon. (Applause.) You have only just begun. The buildings, it is true, are finished, but the sum of money, the estimated sum, if I remember rightly, was twice the amount which has been spent on the buildings; that is, the sum which is required before those buildings can do all that they are called upon to do in the interests of medicine as medicine is now, and to make medicine what it will be in the lifetime of those whom I now address. This is a great task, but it is one not unworthy of the energy and the liberality of our countrymen. (Applause.) Some unacquanted with the movement of modern science may ask why it is that in 1913 we require apparatus, buildings, expenditure of all kinds infinitely in excess of what was necessary even 50 years ago, that is to say, two generations ago. It is not merely the growth of a great urban population, the necessity arises from the in-

herent progress of science itself. Look back 50 years and you will find, in the first place, that some of the branches of science which were then, as they are now, studied by those intending to devote their lives to medicine had, nevertheless, incomparably smaller or less obvious and direct connection with medicine than they have at the present time. Physics and biology, for instance, even some modern parts of chemistry, have a connection with medical science which at one time was not thought to be very real; they had not the connection, the intimate connection, which they now have. The border line between physics and chemistry is now a very difficult and important and rapidly moving branch of science, and it is now intimately connected, and is known to be intimately connected, with all the physiological processes which come into life, those processes on which health and disease alike depend. And as the connection of other collateral sciences is becoming closer with the science and practise of medicine, so the apparatus required has greatly increased in cost, so the amount of knowledge required from the teachers, and the specialisation of the teachers, has itself grown until I sometimes wonder how it is possible for any physician in great practice to even keep himself abreast of what is being done in his own country and by researchers in all the other countries which are now engaged in a happy rivalry over the furtherance of knowledge, a rivalry indeed, far happier than the rivalry in armaments, and I sometimes think hardly less expensive. (Laughter.) To the ordinary public a hospital seems simply to be a place where those who are sick or injured come for healing and relief. That is a very small and a very narrow view to take of its functions, because, unless a hospital was in addition to that a place where the future healers were to be trained, its functions would, as it were, die out with the existing generation, and it would not provide for the carrying on of those great philanthropic duties which for the moment it might perform, but which it would not train our new generations, with increased knowledge and increased command over nature, to carry on in future generations. And it is at least as important that our great hospitals should be made admirable training grounds for the physicians and surgeons of the future as that they should afford to the physicians and surgeons of the present a field for their beneficent enterprise. (Applause.) How is that to be accomplished? After all, one must remember that to carry out this work effectively requires three separate kinds of gifts, which are not necessarily associated in any single individual, in many cases are not, and cannot be. In the first place, in the really successful professor of the healing art you must have not merely a knowledge of the science of medicine, you must have that indeed, but also the happy intuition with the power of diagnosis, and that knowledge of human nature which makes the physician a helper as well as a healer to those whom he has to attend. (Applause.) You must have, in the second place, if a hospital is to be a great school, you must have men who can not only do, but you must have men who can explain. Doing and explaining are very different things, and require very different qualifications. Not always is that so, but very often. They are not always associated in the same individual. How constantly we have found those who can do a thing in any branch of life, I care not what it is, can do it perfectly, who can be trusted to carry it out effectually, but if you ask them to explain their processes, if you ask them to make the ignorant partake of their knowledge, then they are helpless; they can neither inspire others nor can they give others the knowledge on which they themselves half unconsciously work. And then, besides, the man of practical intuition, besides the man who can teach, you want, if your school is to be all that it might be, a man who can investigate, the man who possesses that kind of originality which enables him to see, to map out, not indeed the provinces of which we know nothing, any fool can do that, it is easy to explain what it is we do not know, but, what is not easy to point out, in what direction the next advance should be made, where progress may be expected, where nature may be under existing conditions, most easily compelled to yield up her secrets, and who can by the happy inspiration of genius perhaps suggest a solution of some long-standing difficulty which may throw light upon a multitude of apparently separate phenomena and bring them all under one law and suggest in reference to them one line of successful investigation. That is the researcher. (Loud applause.) Genius is rare in any country and in any profession, and the medical profession cannot hope to have a larger share of it than others. All that organisation can do is to give to these rarely endowed individuals some opportunity in which they can effectively exercise for the common advantage the gifts which God has given to them. I am not sure that our present medical organisation does not need amendment in that respect. Men must live, they must have a profession, we cannot ask them to give up the domestic life and the security of an assured income, and, therefore, if your man of research is going to devote to research hours which might profitably be given to general practice or to the carrying out of his professional work, you must have, so it seems to me, a position of security for him in which he can feel that he is not sacrificing, I will not say his own interests, but the interests of those nearest and dearest to him in the pursuit and advancement of new knowledge. Our system in this country has grown up, like most things in this country, somewhat at haphazard. The result has been a great system. I do not think anyone who is acquainted with the work which our great hospitals have done, not merely in the day-to-day work of healing the sick and afflicted, but in the work which looks to

the future, the work of education, the work of investigation, the work of research, no man can say that they have fallen short of the great duties which they have taken voluntarily upon themselves and for which they have made immense personal sacrifices. And yet I think that such is the movement of modern thought, so rapid is it, so various are the qualities now required of the members of any great scientific and practical profession like the one we are dealing with to-day, so absolutely necessary is it to differentiate more than we have done, in the work of teaching and research, and so impossible is it now to ask that the whole of the teaching and the whole of the research should be done by men engaged more hours than is probably good for their health in the actual trying work of their profession, that I am certain that the public must assist these great hospitals by a form of endowment which will enable them when they get a man with the genius for research, to keep him and to use him. (Applause.) I have come here, ladies and gentlemen, not to make an appeal for the future, but, as it were, to congratulate ourselves upon the past. Yet I cannot forbear, though it may be somewhat outside my duties at the present moment, I cannot forbear formally making an appeal to which I have ventured to lead up by the argument which I have just laid before you. There are, as I have said, men who have got a quite unique talent for research who probably would not be very great clinical physicians, who might have a very small power of expounding doctrines to large bodies of students, and you must find a place for such men when you can get them—there are not many of them—if there is to be a true organisation of medical research for the future. I say you must find a place for those men. It is to the liberality of the general public that I make the appeal. The actual suffering of the moment touches all our hearts. Take a man, the most indifferent, through the wards of a hospital, show him what is being done to diminish suffering, and to restore a man to a happy, fruitful, effective life, and the most callous are moved, and the most indifferent may open their purse strings. The appeal I am making has no such immediate and natural advantages. But I am appealing for the future and not for the present; I am appealing in favour of long academic lines of research, of which the public know nothing, of which if they knew nothing, therefore, they could understand nothing, and yet on which depend the future of the healing art in this and in other countries. (Applause.) A personal appeal is not easy to make; it is apt to fall upon deaf and impaired ears; it does not touch the immediate sorrows of the present; it looks forward through the mists of difficult scientific terms to some unknown future. The future is in this respect as real as the present. Exercise your imagination a little, and you will see that it should touch you just as much as the immediate pain being endured by a man who has broken his leg in the street and is being treated in the hospital behind me. And if only those who have the means will exercise that small effort of imagination which I am endeavouring to elicit, I am certain that those who are responsible for this great institution which I am opening to-day will find it easy to collect the £200,000 which yet remains to be gathered in for all that has been done and turned to the best account. I am sure they will find it as easy to get that £200,000 as they have been able, out of the liberality of the public and of the staff of this great Hospital—(applause)—to obtain that £75,000 which has been collected already for the buildings with which we are concerned to-day. Lord Goschen, I have not yet had the opportunity of seeing these buildings, but I hope to do so immediately; and in the meanwhile now it is my most agreeable duty, ladies and gentlemen, to declare them open. (Cheers.)

VISCOUNT GOSCHEN: I will now ask Dr. Hale White, the Senior Physician of the Hospital, to move a Vote of Thanks to Mr. Balfour.

Dr. HALE WHITE: Lord Goschen, Mr. Balfour, ladies and gentlemen. I cannot imagine a greater privilege or a more difficult task than that of rising to thank Mr. Balfour for what, in my opinion at least, is one of the finest addresses that has ever been given, pointing out the reason why such buildings as he has declared open should be supported liberally. (Hear, hear.) I say that I knew all along he would be the very man to come and declare these buildings open, for as you have heard by what he has said, his mind is in tune with the idea that led to the erection of these buildings; for he is in sympathy with the advancement of knowledge, with students and with scholars, and these are buildings in which students will work; the younger will learn the principles of their profession on the sure foundation of the sciences which these buildings house; the older ones working in the laboratories, some rare few of them gifted with the genius which Mr. Balfour has described to you, will I believe make those discoveries which will advance the science of medicine and will relieve human suffering. Perhaps, Sir, it would not be amiss if for a minute I were to detain you to point out how these buildings came into being. Until the latter end of the last century the sciences of chemistry, physics, physiology, and pathology were in their infancy, and so had very little bearing on medicine. Almost the whole art of medicine then lay in the accurate observation of the phenomena of disease at the bedside and the correlating of the observations made at the bedside with the facts observed in the post-mortem room. Now this School here fortunately had as predecessors of the present staff men who were particularly famous for their skill in that work, such names as Lever, and Bright, and Addison, and Murchison, and Gull, and Wilks, and Foxon, and Golding-Bird and others which come to one's mind as having made this School famous for that particular way of attacking medical problems. I remember an American writer said, speaking of the men of that time, that the outstanding feature of the

men at Guy's was their original descriptions of disease. Well, now, the sciences to which I have alluded grew, and it became obvious to us physicians and surgeons that they could be greatly utilised to explain many medical problems that we wanted solved; in other words, they served to advance our knowledge. Seventy years ago a very distinguished gentleman attached to this Hospital, namely, Hodgkin, wrote saying that it would be his constant endeavour, however far short he might fall in the aim, to extend to the utmost of his powers his help to those who were then engaged in rendering the Medical School of Guy's Hospital the first in the field. The same sentiments which animated Hodgkin 70 years ago animate the staff here now. (Applause.) And those sentiments animated the staff 20 years ago as animated Hodgkin, and accordingly, the staff then said these sciences have now come to that state of perfection when they can materially help us to advance our knowledge, and we must build buildings in which we can house them; laboratories where they can be worked out, laboratories where the professors can not only train the students, but where they can do their original work, and where the man of genius shall have apparatus. The result is the buildings which Mr. Balfour has declared open, and I should like here to repeat once more what Lord Goschen said: "that not one single penny of the money from the Hospital has been spent on these buildings." (Applause). Many kind friends have helped us, Mr. Gordon has helped us. (Applause). But I want to point out further, that although many kind friends have helped us, many thousands of pounds of the money have come from students' fees, which the staff, when they started these buildings 20 years ago, would have been perfectly justified in putting into their pockets, but they did not do so, they diverted the money from their pockets to the buildings. (Hear, hear, and applause). It may be said "Oh, that was done because it would lead to an increased number of students coming." But that was not the motive, and the proof that it was not the motive is this: That the people who suffered most severely amongst the staff from loss of fees through putting them into this building have left us now, they have retired. They voluntarily gave up their fees in order that there should be buildings in which the great traditions, founded by the observers of 50 years and 100 years ago at this Hospital, should be carried on. The staff wanted to feel that there were buildings where anatomy, physiology, chemistry, physics, pathology, and bacteriology could all be developed as sciences, making this not only a great hospital, but a great medical school, a school where knowledge could be advanced, where teaching could be carried on, and whence students could be sent into the world well-trained and well-taught to think for themselves, and men, in every respect, a credit to the Hospital, who had received these glorious traditions from its predecessors. One word and I have finished. It is this, as Mr. Balfour has truly said, you cannot possibly have a hospital without workers. It is no good having workshops unless there are workers to work in them. To supply a few details of what he has told you of the lectureships here, I may say that only one is endowed, and that only in part. We do feel strongly that with a hospital with such traditions as this, with such enthusiasm in it, and with such laboratories as these, we are not asking much in asking that the lecturers and teachers in it shall be properly paid, and that they shall be men of rank and eminence in their profession. (Applause.) Unfortunately it happens that lecturers here have to leave us sometimes to go to posts which are endowed. We are the losers, and the more is the pity. But in making this appeal, I do not appeal solely to people in this island. This Hospital and this School have a very wide reputation in the Colonies and in India. Many of our best students come from India. We have with us to-day, I am glad to say, Sir Richard Solomon, from South Africa, and the Hon. Mr. Mackenzie, from New Zealand. Many of our best students go to practise in the Colonies and India. So I think I may appeal not only to the inhabitants of this island, but also to the inhabitants of the whole of the Empire, to come and help us. If anyone feels generously inclined he cannot, I think, show his generosity more than by endowing, or partially endowing, one of the demonstratorships or lectureships here. If he will do that he will be adding to the common fund of knowledge, he will be promoting learning, he will be helping the students to be properly trained and to go all over the world in the exercise of his profession in a proper way, he will be sowing seed which will blossom for all time. Contrast the giving of £20,000 for a picture by a dead artist and the giving of £20,000 to endow a lectureship to a medical school. (Applause.) Ladies and gentlemen, I have only to mention to you the contrast for you to see on which side the advantage lies. (Applause.) Ladies and gentlemen, I am perfectly certain that you will agree with me in heartily thanking Mr. Balfour for the address he has given us. (Applause.) By coming here to-day he has helped this Medical School immensely, and he has helped it forward on what I am certain will be its onward march of progress. His coming here to-day and his delivering of quite one of the most admirable addresses which it would be possible to deliver opens a new chapter in the history of this School, and I am perfectly certain you will agree in thanking him very heartily for it.

LORD GOSCHEN: I will ask Sir Arbuthnot Lane to second it.

Sir ARBUTHNOT LANE: Lord Goschen, ladies and gentlemen, Mr. Balfour has in a magnificent speech appealed to your pockets. Dr. Hale White has followed suit. I will not appeal to your pockets, I will appeal to your pride. There is no country in this world in which research is worse paid and worse looked after than it is in England. In the States Rockefeller pours his millions into the lap of the scientific man. There the scientific man is looked after and nursed. Here there is the man who commands and the man who beats.

But there is another kind of man whom you must nurse. I do not think I can do better than tell you a little story. My house used to be occupied by Mr. Hargreave, who was architect to the Bank of England. He used to get his hair cut near the Bank of England at a Mr. Turner's house. Young Mr. Turner was not very successful in cutting hair, and customers complained about him. Mr. Turner said his son was no good. Mr. Hargreave said, "Send him round to my house, he can dust my room." For two years that son dusted the rooms occupied by Mr. Hargreave at the house I am living in. Then Mr. Hargreave took him on as clerk in the house, and then he discovered quite by accident that he was a genius. It was Turner the painter. That is the kind of man you have to nurse, you have to look after him. The strong man will look after himself, in fact you cannot keep him down. You should make preparations for the other kind of man, for he is often the greater man. I join heartily in your thanks, ladies and gentlemen, to Mr. Balfour for his address to-day. (Loud applause.)

The Rt. Hon. A. J. BALFOUR: I assure you I think it a great privilege to come here on this auspicious occasion, and I most heartily thank you for the way in which you have received my few remarks.

The Company then adjourned to the new buildings.

University of London Officers Training Corps.

Medical Unit. B Section.

NOTICES.

1. *The Annual Inspection* will be held on Saturday, June 28th. Cadets are reminded that attendance at this is necessary in order to become efficient.

2. *Camp.*—This will be at Tidworth from July 19th to August 2nd. To become efficient one week only is necessary. It is, however, sincerely to be hoped that all Guy's men will put in the whole fortnight. To all, this is now possible. Those who are not in the wards can well afford a fortnight out of the long summer vacation. In order to help those in the wards, the School has passed a regulation to the effect that a fortnight spent in camp by any member of the O.T.C. shall only count as one week towards the four weeks' holiday allowed in each year, and that on each firm, men wishing to go to camp shall have first choice of holiday during the summer months.

3. *Advance Party.*—An advance party will go down on Wednesday, July 16th. Anyone wishing to join it must send in his name at once.

4. *Promotion.*—To be Cadet Lance-Corporal, Cadet E. Biddle.

5. *Certificate B.*—Cadet J. Stephenson has passed the examination for this certificate.

T. B. LAYTON,
Lieut., R.A.M.C. (T.),
O.-C. "B" Section.

The School in the Past.

ALTHOUGH it is true that a great general hospital must always have an educational value it would be a mistake, for more than one reason, to give the Guy's School of Medicine an origin as early as 1725 when the parent institution was first opened. Medical education was not placed upon a systematic basis until many years later, and even then the conditions of the partnership in medical teaching shared by this hospital with St. Thomas's precluded either institution from claiming an individual School as long as the union lasted.

In the early eighteenth century the leading members of the Barber-Surgeon's Company (as it then was) naturally had their headquarters in London where the great hospitals existed. In London also was the Society of Apothecaries, members of which were in residence at the hospitals in full charge of the patients except during the occasional visits of the Physicians on the staff. The Physicians, on the other hand, owed their prime allegiance to the Universities that imparted the empirical views of Medicine current at the time and conferred their degrees.

The more practical methods of instruction would seem to have been developed afterwards in response to the requirements of the main body of the profession who qualified for practice by a system of apprenticeship.

In the early days of Guy's there were no class-rooms; and no lectures were delivered apart from the purely clinical instruction imparted by the Surgeon or Apothecary on the staff to his bodyguard of "cubbs," or apprentices. Early in the history of the Borough Hospitals a system of interchange was made possible by which the apprentices of one institution were permitted to see the surgical practice at the other; and at length the surgeon's audience grew to proportions that warranted the establishment of regular series of lectures. For some time previously members of the staff had been conducting private courses of instruction at their own houses, and the authorities at length realised the advantages that would accrue to the hospitals if lectures were established here. At St. Thomas's, therefore, a theatre was erected where lecturers, appointed from time to time from either of the Borough staffs, discoursed on Anatomy and Surgery to a mixed audience from the two United Hospitals.

The teaching of Medical subjects soon followed. Dr. William Saunders, who had been lecturing with considerable success at his private house in Covent Garden, was induced to join the staff at Guy's in 1770, and to continue his lectures there. For this purpose was built the old "Chemistry" theatre that survives almost unaltered to the present day. Curiously enough, unlike the anatomical, the medical lectures were always delivered by members of the Guy's staff despite the protests of their colleagues of St. Thomas's. The Physical Society at Guy's was founded as early as 1771.

The benefits derived from the new methods of instruction were set forth in a report rendered to a committee of St. George's Hospital in 1793. The lectures "consist of Midwifery, Surgery, the Materia Medica, with the Practice of Physick, of Chymistry, and Anatomy. The fees arising from an attendance on either or all are appropriated to the different professors only (for none are read gratis), and are not shared by either the physicians or the surgeons belonging to the hospitals. The obvious advantage of such an arrangement is this, that the pupils designed for either profession have not only set before them a complete class of such lectures as they may choose to attend, but do not lose a very considerable portion of their time in the morning now appropriated to those pursuits by running about at great distances from one lecture to another and to the hospital, always inconvenient and sometimes impossible . . . . . As for fees for attendance, those for apprentices excepted which are always private, as are those for dressers, indeed, at the Hospitals of St. Thomas and Guy's and St. Bartholomew's and belong to their respective surgeons . . . . . for one year for general attendance only, £25, for half a year £18."

Dissecting was undertaken by the students of both hospitals within the school premises of St. Thomas's. A dissecting-room was in existence at Guy's, however, before the close of the eighteenth century; it was known as "Cooper's Room," and had been granted to Mr. William Cooper for his private use, and specially favoured pupils were allowed to dissect there. After he had been succeeded in 1800 by his famous nephew, a larger room was requisitioned, and in it were prepared some of the dissections that illustrated Sir Astley Cooper's lectures in the theatre at St. Thomas's. It is probable that a number of pupils elected to dissect here rather than across the road, for Sir Astley appointed Mr. Saunders as Demonstrator, a post which he held until his death in 1810. The official course of dissections was only followed during the Winter and Spring Sessions at this period, and students desirous of continuing their studies in this department were obliged to resort to one of the many private anatomical schools then existing in London.

An advertisement that appeared in the "Morning Chronicle" of January 23rd, 1815, gives a view of the curriculum offered by Guy's in the early part of the century.

"MEDICAL SCHOOL OF GUY'S HOSPITAL.—The Spring Course of Lectures will commence the beginning of February, viz.: Practice of Medicine, by Dr. Babington and Dr. Curry; Chemistry, by Dr. Babington, Dr. Marcet, and Mr. Allen; Experimental Philosophy, by Mr. Allen; Theory of Medicine, and Materia Medica, by Dr. Curry and Dr. Cholmeley; Midwifery and Diseases of Women and Children, by Dr. Haighton; Physiology, or Laws of the Animal Œconomy, by Dr. Haighton; Structure and Diseases of the Teeth, by Mr. Fox.—N.B. These several Lectures, with those on Anatomy, and on the Principles and Practice of Surgery, given at the Theatre of St. Thomas's Hospital adjoining, are so arranged, that no two of them interfere in the hours of attendance; and the whole is calculated to form a Complete Course of Medical and Chirurgical Instruction.—Terms and other particulars may be learnt from Mr. Stocker, Apothecary to Guy's Hospital."

Early in 1825 occurred the cleavage between the Borough Hospitals, and, as a result, Mr. Benjamin Harrison, the Treasurer of Guy's, actively supported by Sir Astley Cooper, refounded the school on an independent basis. The only difficulty experienced was the necessity for creating a new museum; for the authorities of St. Thomas's had refused to surrender any part of the museum of the joint school, although very many of the preparations in it were the work of Sir Astley's own hands. Eventually he was awarded a sum of money by way of compensation, and this amount he handed over to Mr. Harrison towards the expenses of the new buildings at Guy's. A museum had existed there previously, however, for the catalogue of 1804 shows a considerable number of specimens, whilst numerous additions were were made by Mr. Travers two years later.

When the new school was opened Aston Key and John Morgan were installed as lecturers on the Principles and Practice of Surgery, and with the assistance of Bransby Cooper they also conducted the courses on Anatomy and the Operations of Surgery. Morgan also lectured on Ophthalmic Surgery at this time. The first demonstrators of Anatomy appointed were Edward Cock and John Hilton.

The dissecting room formed part of the museum buildings erected in 1825. In 1850 these buildings were much enlarged, this room was thrown into the museum as its south wing, and the present dissecting room was erected on a site adjoining. In 1873 the demonstrating theatre was added to the anatomical department; in 1878 class-rooms were added to the museum; and ten years later two physiological laboratories were put up near by. After the construction of the Gordon Museum the old building was demolished and its site is now occupied, in part, by the nurses' portico.

Shortly after the foundation of the new school, Mr Harrison, at the instance of Sir Astley Cooper, had the good fortune to engage Joseph Towne, as modeller to the hospital. His famous wax models, now the glory of the Gordon Museum, were formerly lodged in what is now the biological department, on the ground floor of the Medical Buildings. Many of the anatomical models were prepared from careful dissections made by John Hilton. Harrison also engaged an artist named Canton, but of him and of his successor, Hurst, no such valuable relics are preserved. A third artist, John Lucas Tupper, used to be represented in the old museum by his accurate drawings of "skeleton swordsmen."

In 1826 Dr. Bright began to lecture on Medical Botany, to meet the requirements of the Apothecaries' Society, and then also were established the semi-farcical botanical excursions. The lectures continued until they

were superseded in 1886 by others on Therapeutics. Medical Jurisprudence was first taught by Dr. Swaine Taylor in 1831.

Midwifery lectures had been delivered as early as 1770, but practical instruction in this subject only became possible after the establishment of the Guy's Extern Charity in 1833. With Midwifery, Physiology had been associated in the early days, but in the year last named, Dr. Blundell devoted a special course to it. After his time Physiology was grouped with Anatomy until Gull was appointed Physiological lecturer in 1846. Dr. Hodgkin delivered the first lectures on Morbid Anatomy in 1835; but records of post-mortem examinations have been preserved at Guy's since 1814. Morbid Histology was introduced about 1872. Demonstrations in Microscopic Anatomy had been given by Mr. Birket in 1845, and Dr. Pavy added Histology (as it was afterwards called) to his Physiology course in 1857. Practical Chemistry was introduced by Dr. Odling in 1852, and Operative Surgery by Mr. Bryant in 1859.

In 1860 the lunatic patients were removed from the old building in the Park, and the Clinical Wards, previously lodged in Job and Lydia, were transferred thither. The Medical Building—Hunt's House—was completed in 1871, on a site formerly occupied by small buildings containing the obstetric wards and the children's wards. A practical chemistry laboratory was put up in the same year to the west of the surgical block; one of the laboratories behind the old theatre is much older, and contains an eighteenth century marble medallion to Robert Boyle.

In 1870 the Guy's Hospital Gazette made its first appearance, thirty-four years after the first "Reports."

Dr. Fagge introduced the subject of Hygiene in 1870–1. In the same year Insanity was first lectured upon by Dr. Thompson Dickson; and it was due to the influence of Dr. Savage, who followed him after four years, that students from Guy's were allowed to see the mental cases in Bethlem.

In 1889, was established the Dental School, although as we have seen, dental subjects had been lectured upon by Mr. Joseph Fox at the beginning of the nineteenth century.

In the early 'nineties, new buildings were erected in the "Petersham" division of the Hospital, replacing a group of wards so named after William Hunt's estate in Surrey. These were the laboratories for Chemistry, Physics, and Bacteriology, as well as the ever-growing Dental School.

The College, having been projected as far back as 1840, finally came into being in 1890, and to it was transferred the Students' Club, which had previously, from its foundation in 1887, been lodged in a disused ward. The late Dr. Pavy presented the Gymnasium in 1890.

Before the Wills Library was opened the old library occupied the north-west corner of the western quadrangle of "Guy's House." It was placed in a dark angle—like the squares concerned in a "Knight's move," for shape—between the Superintendent's office and the extremity of Cornelius ward. Cornelius has since been extended to include a narrow passageway that led to the Chemistry Department, as well as a portion of the old library premises beyond it.

In 1897 was opened the building containing the Physiological Theatre, and since that date the sequence of New School Buildings, as well as the Nurses' Home, has been constructed.

Appointments.

Naval and Military.

Major R. Tilbury Brown, R.A.M.C., has been appointed to command the Military Hospital, Darjeeling Cantonment.

Captain T. C. Lucas, R.A.M.C., has been appointed Surgeon to the Governor of Bombay Presidency.

Captain D. P. Watson, R.A.M.C., has taken up the appointment of Clinical Pathologist, Queen Alexandra's Military Hospital.

Lieutenant D. Reynolds, R.A.M.C., has embarked for India.

Special Reserve, R.A.M.C.—Lieutenants on Probation M. K. Nelson and Travis Hampson are confirmed in their appointments.

Civil.

C. D. Outred, M.R.C.S., L.R.C.P., has been appointed District Medical Officer, Gravesend and Milton Union.

The Milward Fund.

THIRD LIST OF DONATIONS.

	£	s.	d.
Previously acknowledged	128	2	6
R. Hilton Fagge, Melton Mowbray	2	2	0
T. L. Jackson, Cheadle	1	1	0
H. A. Latimer, Tunbridge Wells	1	1	0
Albert Shepperd, London	0	10	6
J. R. Steinhaeuser, Lewes	1	1	0

Particulars of the Fund can be seen in the GAZETTE of May 10th.

Further Donations will be gratefully received by the Hon. Treasurer, Mr. William Sheen, 2, St. Andrew's Crescent, Cardiff.

Change of Address.

J. H. Jones, M.R.C.S., L.R.C.P., from 126, Unthank Road, Norwich, to New South Wales Club, Bligh Street, Sydney, N.S.W.

J. Roberts, L.D.S., from R. N. Barracks, Chatham, to 43, High Street, Sittingbourne.

Notes from Spain.

I. El Medico Ingles.

IT is said, I believe, that there is a Guy's man in every part of the world, so fate, I presume, has sent me here in middle age as the inevitable representative of our old hospital. Las Arenas, where I live, is a suburb of Bilbao, at the mouth of the River Nervion, and about eight miles from town. A train comes and goes every half hour on both sides of the river. There is a tramway also on either bank.

Most of the English residents live in this suburb, or in Portugalete on the opposite side. It is a mercantile community of a few hundred Britishers engaged in the shipping and iron ore industries. There is very little illness among them, but they profess to like the presence of an English doctor in the neighbourhood. The natives look upon "El Medico Ingles" as a kind of official connected with the English community. Apparently, he possesses no name; letters come addressed merely to his descriptive title; parcels and bills equally bear this label. If he were to go bankrupt, or die and be buried in the British cemetery, I believe he would be considered as sufficiently described in this locality as "El Medico Ingles." The Spanish doctors also regard him with a friendly eye, and, before he acquires a "licence," sign "certificates" for him when called into consultation for that purpose. The strange idea of illegality in "covering" an unlicensed practitioner appears to be unknown here.

My first meeting with a Spanish consultant was over a case of typhoid. Not knowing Spanish, I conversed with my colleague through an interpreter. He seemed highly delighted at the interview, and every now and then would rush forward and clap me on the back. Wishing to show an equal geniality, I returned the compliment in similar fashion, and our discussion then became punctuated by a sort of double-shuffle interspersed with bangs in the back. At this corybantic consultation it was decided to have a Vidal's test taken, and the result being "positive," the patient was taken into the Civil Hospital by the genial physician before mentioned. Under the "do nothing" treatment he got quite well. He was kept in a very cold room, and allowed to get up to pass his evacuations all through his illness. His temperature at times ranged over 105° F. It is interesting to note that he suffered no inconvenience from being taken to the hospital on a jolting stretcher for a distance of several miles.

What first strikes a stranger is the muscular powers of the working women. From youth to old age they are accustomed to carry enormous weights on their heads. The result is seen in their fine carriage. Here are no narrow chests, no sloping shoulders. The body is perfectly balanced. A servant-maid thinks nothing of moving about the heaviest piece of furniture unassisted. They are a fine race about here, probably the finest people in the whole of Spain.

As an observer, another point strikes me. I am told syphilis is very prevalent here, but, looking at the physiognomy of the people of all classes, I fail to see any signs of hereditary taint such as one might suppose to see. Either the type of syphilis is of a specially mild character or the treatment is specially good. Probably both can account for it. Syphilology is a popular subject of conversation all over Spain. I have seen a café in Seville with a brilliant electric sign over the door, "606"! There is another similarly named in Malaga. At clubs men discuss their lesions quite openly. I remember one chatting about his personal experiences of Salvarsan, and pulling down his lower lip to show where a *plaque* has been before he underwent the treatment. What corresponds to the Contagious Diseases Act prevails here, but, like everything else in Spain, the working of the law is very lax. Medical etiquette is a strange thing in this country. The newspapers contain doctors' advertisements, and similar announcements are seen outside the houses and offices of many of the faculty.

Within a short distance of my house stands the Parish Infants' School, and in the same building without any architectural distinction is a slaughterhouse for lambs. What one sees there almost daily would be impossible in England, but apparently here it is nothing unusual. The school stands on one side of the street, and the little boys and girls play in the roadway between school hours. One of the commonest sights for the passer-by to see is a small crowd of little ones pressing around the open door of the slaughterhouse watching with eager eyes the lambs being killed. Occasionally a child will dart inside and seize some glandular organ and play ball with it. Sometimes the children, making a pile of the living lambs (whose legs are tied together), will watch the struggling movements of the woolly heap. This weird sight might well make the psychologist predict an awful moral effect upon the minds of these bloody-handed children. Probably he would be totally wrong, for the children never seem happier than when showing affection for one another, and a more kindly set of people than the Spaniards it would be difficult to find. Kindness to animals has nothing to do with kindness to human beings. It is merely a beautiful thing of itself.

It is curious to note how differently on either side of the Franco-Spanish frontier cats are regarded. At Biarritz the feline purrs in security at the open door. He or she is the pet of the house. At San Sebastian, on the other hand, a cat is a hunted being, and flies from one in fear. The reason for the latter is that in Spain he is regarded as an inferior rabbit, and as such is killed and eaten. Here it is rare to

meet a friendly cat, but birds seem to be regarded as desirable beings if one judges by the enormous number of bird cages hanging up in the "miradors" everywhere.

Except for cats, this is a happy land. People insist on being happy, and in spite of anything look happy. I have seen happy lepers in Seville; gay laughing lepers! Nothing interferes with the joy of life here. A terrible tragedy occurred in Bilbao recently: forty-two children were killed. The relations were all photographed together for an illustrated paper. Looking at the group it would be impossible to say that even one looked sad. Every Sunday afternoon in the *plaza* here a band plays and all the young people of the town dance for several hours together. There is no drunkenness or horseplay anywhere. Lovely girls are as common as blackberries, and their neat modern costumes show off their splendid figures to perfection. Their hair is always well kept, beautiful ropes of hair shining like metal. Their small feet are always well shod, and their bright and smiling faces show that for them there is no monotony in life. Place a misanthrope among them and he will catch their joyous infection. It is, indeed, a country of delight—delight in simple pleasures.

Las Arenas, Bilbao, Spain,
May 1st, 1913.

FREDERIC VICARS, M.D.

Guy's Hospital Ladies' Association.

Her Royal Highness, Princess Christian, presided at the Annual General Meeting of the Guy's Hospital Ladies' Association which was held in the Court Room on Tuesday, May 27th, at 3.30 p.m., when about 150 members were present.

On arrival at the hospital Her Royal Highness was received by Mr. and Mrs. Cosmo Bonsor, Lord and Lady Goschen, the Matron, Mrs. Benyon, and other members of the Committee.

In the unavoidable absence of the Hon. Treasurer (Mrs. Pye-Smith), Mrs. Hale White moved the adoption of the statement of accounts for the year, and Mrs. Stanley Mason seconded them.

The Hon. Secretary, Mrs. Lauriston Shaw, next read the Committee's report of the year's work, from which it appeared that the Association was in a very flourishing condition, having a membership of over 1,500. It was able to give a donation of £400 to the hospital to support seven beds in Queen Ward besides two cots.

The adoption of the report was moved by Mrs. Benyon, and seconded by the Matron, who said she took this opportunity of thanking all the members who had worked so hard and had sent such a quantity of useful garments for the patients, as well as cushion covers, etc., etc., for the wards. The work of the Ladies' Association was of immense benefit to the hospital and was greatly appreciated.

On the proposition of Mrs. Mollison, seconded by Mrs. Fagge, the Hon. Mrs. Farquhar and Mrs. Philip Turner were elected to fill the vacancies on the Committee.

The Hon. Mrs. Molyneux proposed, and Mrs. Cosmo Bonsor seconded, that the Matron be elected ex officio a member of the Committee.

Lord Goschen, in proposing a vote of thanks to Her Royal Highness for presiding, said he would like to express the great gratitude they all felt to Her Royal Highness for coming to them that afternoon. Guy's was very fortunate in the generous support they had always received from members of the Royal Family; the late King Edward had always been interested in the hospital, and only last year the present King and Queen Mary paid a visit to the hospital, and had given much encouragement to all by the practical and kindly interest they took in everything they saw. He would like as Treasurer to express to the members of the Ladies' Association the grateful thanks of the Governors, and the patients, for the valuable work they had done and were doing. Over 1,000 garments had been contributed by the members, in addition to the larger number designed for special wards.

Mr. Cosmo Bonsor, in seconding the vote of thanks, said the presence of Her Royal Highness was a great encouragement to the Ladies' Association and to all who worked in the hospital. Lord Goschen had spoken of the sympathy which they had always received from the Royal Family. It was now more than 20 years ago that the late King Edward had become their President, and had inaugurated an appeal for funds at a time when the hospital was in great difficulties; they had closed two wards and were on the point of closing a third, and the whole of the hospital was out of repair, but through His Majesty's generous support and timely help they had been able to clear off the entire debt. He looked forward to being able to welcome another member of the Royal Family as their President, for he considered he only held the office until such time as His Royal Highness the Prince of Wales would graciously accept it.

After the meeting, Mrs. Benyon and Mrs. Bonsor entertained Her Royal Highness to tea in the Superintendent's House, the Vice-Presidents, Committee, and Local Secretaries being also invited. The Princess afterwards visited two of the wards.

Tea was served in the large Committee Room for the members who also inspected the garments, etc., contributed by the various branches. Many members availed themselves of the opportunity to visit the hospital, several of the Sisters kindly acting as guides.

Sanatorium Benefit.

BY ALEXANDER SANDISON, M.B., B.C., B.Sc.

Medical Officer to the Tuberculosis Dispensary for the County Borough of Croydon.

THAT portion of the Insurance Act which deals with Sanatorium Benefit has now been in operation for over nine months, a sufficiently long period to enable us at least to see in outline the general prospects of this determined effort on the part of the nation to deal effectively with the problem of Tuberculosis.

The main foundation upon which the whole scheme rests is the Interim Report of the Departmental Committee on Tuberculosis, more commonly known as the "Astor Report." It is there recommended that the machinery to be set up for dealing with tuberculosis should consist of two units: a "dispensary unit," with a staff of expert clinical officers; and an "institutional unit," comprising sanatoria and hospitals. The organisation of the dispensary unit is regarded as of special importance and as being the pivot upon which the whole scheme must turn. It is to act as the clearing house through which all tuberculous persons must pass, as the centre for the examination of "contacts," and for the after-care of those who have returned to work; as an educational centre for the dissemination of information regarding tuberculosis, and as a place where valuable clinical and statistical records may be accumulated. On the average, it has been estimated, that one such dispensary will be required for every 150,000 to 200,000 of the population in urban districts, and to a greater extent in rural parts.

The staff of the dispensary is to comprise, first and foremost, an expert medical officer (usually known as the "Tuberculosis Officer), who, in addition to having held resident appointments at a general hospital, has had detailed experience in the treatment of tuberculosis at a special hospital or sanatorium. The initial salary recommended for this officer was £500 a year, and it is satisfactory to note that, with few exceptions, this recommendation has been adopted by the local bodies making the appointments. This officer is clinically independent and entirely responsible for the treatment of all persons under his care. Administratively he is attached to the Public Health Department of the authority for which he works, and thus is under the administrative control of the Medical Officer of Health. The relations between the M.O.H. and the Tuberculosis Officer are difficult precisely to define—they must work in harmony and in co-operation. Where the general health of the district is concerned, the M.O.H. must necessarily be the final authority, but, on the other hand, the M.O.H. is not regarded as specially expert in the problems of tuberculosis, diagnostic or therapeutic, and where the detailed treatment and care of the patients is in question, the Tuberculosis Officer must be entirely independent and directly responsible to none save the committee under whom he acts.

It is thus at once apparent that a new medical service has been set up in the country, a service consisting of men who are expected to be specialists in a particular disease, and whose work is mainly of a clinical character, though at the same time, they are intimately in touch with, and, to a certain extent, responsible for, administrative public health schemes. They are being paid a salary which is considerably in advance of the initial salaries of the ordinary Public Health Service, and it is possible to secure these posts within a comparatively short time after completing a period of resident appointments at a general hospital. Compared, therefore, with the ordinary Public Health Service, Tuberculosis Officerships offer certain definite advantages. In the first place, those who take them up are not cut off from the interests of clinical medicine; on the contrary, they are expected to be, and to keep themselves, expert clinicians. Much of the work, as I shall shortly indicate, is of a consultative character, the Tuberculosis Officer acting officially as the "consulting officer" in regard to insured persons. On the other hand, whilst not mainly an administrative appointment, yet the connection with the general public health work is so intimate that in many ways the officer secures the advantages of a share in administration without its disadvantages, and especially without the divorce from clinical medicine which is to many a repellant feature in the Public Health Service.

From the financial standpoint, considering that no capital outlay is required, as in buying a practice, the position of the officers is not unsatisfactory, and certainly affords the most immediately remunerative opening possible at the present time. Furthermore, the actual work has the great advantage of being confined to definite hours; there are no night-calls, the week-ends and evenings are free, and the yearly holiday is adequate and secure. Thus, there is time for research work, and, in short, for living and not merely existing.

As to the prospects of the service, it is, of course, difficult to prophesy, and divergent opinions may be held. From the broadest point of view, however, it is, I think, not unjustifiable to predict that when a nation such as ours thus initiates so extensive a scheme for dealing with a ubiquitous disease, that the possibilities of development are great and that the extension of the service will probably be far greater than any imagine at the present day. It is, perhaps, in some ways a risk, but, provided that those who are the pioneers in the service realise their position and their possibilities, they ought, I think, to develop an organisation which will be in every way a credit to clinical and administrative medicine, and one which

later on may be employed to deal with many other aspects of disease beyond tuberculosis.

To turn now to the actual administration of Sanatorium Benefit as it is being carried out at present. The details for such administration are left, to a very large extent, in the hands of the local County and Borough Councils, who are, of course, guided by their M.O.H. and by the suggestions of the Local Government Board. Thus, the various towns and counties are in very different stages of progress in regard to the carrying out of their plans, but the majority of them have by this time appointed one or more Tuberculosis Officers, and have started to set their house in order. Croydon, for example, the County Borough to which I have been appointed, has, owing to local difficulties, not yet been able to set up a Tuberculosis Dispensary as an independent building, but this has not prevented Sanatorium Benefit being given in a satisfactory manner for the time being. Incidentally, the term "Sanatorium Benefit" is an unfortunate one, for to the lay mind, and especially to the mind of the insured person, it naturally implies treatment in an actual sanatorium. Of course, as a matter of fact, such treatment would be quite unsuitable in a considerable proportion of the cases, and the term in reality implies (as is stated in the Act), four main types of treatment, viz.:—

1. *Domiciliary.*—Treatment in the patients' own home by his own doctor in consultation with the Tuberculosis Officer. Milk and eggs, cod-liver oil and malt, thermometers, sputum flasks, etc., are supplied if necessary.

2. *Dispensary.*—For those patients who are able to be up and about, and are fit to work, for "after-care," and for "contacts." This treatment is carried out by the Tuberculosis Officer himself and his staff, and is very similar to an out-patient department.

3. *Institutional.*—For cases of doubtful diagnosis requiring observation, for advanced cases, and for cases where the home circumstances are unfavourable, but the patient is not suitable for a Sanatorium. Under this heading come also those cases which require a short training in personal hygiene and the method of open-air treatment, so that they can subsequently look after themselves at home. At Croydon a number of beds have been allotted for such cases in the Borough Isolation Hospital, and in the near future a special extension of the hospital is to be made to give fuller accommodation. At present the cases are in a special pavilion, and are there able to have thoroughly effective treatment. The beds are under the immediate charge of the Resident Medical Officer, but the Tuberculosis Officer acts as visiting physician in regard to them.

4. *Sanatorium.*—For those cases specially suited for such treatment. Up to the present time most local authorities have reserved certain beds in various existing sanatoria to which they can send their cases, but later on special sanatoria will have to be built for the different districts.

The allotting of the various patients to these different forms of treatment is one of the main functions of the Tuberculosis Officer, and it will be seen that, except in the case of those actually in sanatoria, he is in constant personal touch with every case. He is thus in a position of great advantage with regard to the cases under him, for, unlike the private practitioner or the hospital physician, who are so frequently compelled to lose sight of their patients, he is able to follow them personally, and with his own stethoscope, through almost every phase of their treatment, and, as time goes on, will acquire a unique acquaintance with their condition and idiosyncrasies, whether they be well or ill. In this, it seems to me, lies the great clinical advantage of such posts, for there are few, if any, other positions where the same man can himself follow the course of his patients, in their homes, as out-patients, in hospital, and again when back at work as cases for after-care.

The decision as to the kind of treatment suitable rests solely with the Tuberculosis Officer; each case is referred to and examined by him at the outset, and he is supplied with monthly reports from doctors and sanatoria as to their progress, and himself sees and examines domiciliary cases in consultation with the doctor as often as seems necessary.

Closely bound up with this clinical work is the sanitary aspect of the problem, and here the staff of health visitors, sanitary inspectors, etc., play their part under the direction of the M.O.H., who is at once informed of the sanitary and home conditions of the patients. A nurse is specially attached to the dispensary to assist the Tuberculosis Officer there and to visit the patients' homes.

The ultimate control of the whole work lies partly in the hands of the Insurance Committee and partly with the County or Borough Council concerned. The financial details of the scheme are intricate, and involve constant co-operation between the Insurance Committee, which makes recommendations, and the Council, which endeavours to carry them out. The Tuberculosis Officer is chiefly responsible to the Insurance Committee, as it is to it that he directly reports his treatment of the cases for approval and confirmation, whilst the M.O.H., working with the Sanitary Committee of the Council, is responsible for the broad administrative plans.

So far, few, if any, Councils have extended the work to include the dependents of insured persons, other non-insured persons, and children, but such extension is bound to come, and the Government have made definite provision for it. It would obviously be futile to confine the attempt to eradicate or control the disease to insured persons alone, and the inevitable sequence of the work already done is the inclusion of *all* cases of tuberculosis within the scope of the work

of the Tuberculosis Officer and the provision of Sanatorium Benefit. In the same way it will be necessary to deal with non-pulmonary tuberculosis on a similar basis. Such extension opens up the widest possible field for clinical endeavour, and should inspire those in the work to look forward to a time when, if not necessarily eradicated, yet tuberculosis will be kept in subjection and control, and, this having been accomplished, the machinery set up may be used also to deal with other perhaps equally devastating diseases.

In conclusion, mention must be made of the recommendations of the Astor Committee in their final report with regard to provision for research work. A sum of about £57,000 a year is to be allotted to this branch of the scheme, and proposals are made for the establishment of a central bureau which can co-ordinate and systematize the work of the various dispensary and institutional units. Valuable statistical, sociological and clinical information must thus be acquired, and, in addition, special grants are to be made for research work in the laboratory and in the wards. It is hoped also that dispensaries may be attached to the great medical schools, and thus form a training ground for the service, and in any case each dispensary should endeavour to become a local teaching centre as far as possible.

"Sanatorium Benefit" is thus an innovation in medical work of an entirely new and unprecedented kind. It has been conceived on a vast scale, it teems with possibilities, and its future rests with those who at its outset devote to it the interest and keenness which never fail to secure success.

Papers by Guy's Men.

H. L. Eason, M.D., M.S.: Diseases of the Eye.—*Polyclinic*, June, 1913.

A. E. Boycott, M.D., and J. H. Ryffel, M.A., B.Sc., B.C.: The Action of Diuretics in Experimental Nephritis.—*Journal of Pathology and Bacteriology*, Vol. XVII., No. 4.

R. A. Chisolm, M.D., M.R.C.P.: Note on the Nitrogen Content of Malignant Tumours in Man.—*Ibid.*

D. Forsyth, M.D., D.Sc., F.R.C.P.: A Post-graduate Lecture on Disorders of Speech as Evidence of Nervous Disease.—*Clinical Journal*, 28th May, 1913.

F. W. Langridge, M.R.C.S., L.R.C.P.: Clinicalia—*Ibid.*

G. W. Nicholson, M.D.: Changes observed during the Absorption of Experimentally produced Sarcomata.—*Journal of Pathology and Bacteriology*, Vol. XVII., No. 4.

E. Bellingham Smith, M.D., M.R.C.P.: Asthma in Children.—*Practitioner*, June, 1913.

T. G. Stevens, M.D., B.S., F.R.C.S., M.R.C.P.: A Clinical Lecture on Salpingo-oöphoritis. — *Clinical Journal*, June 4th, 1913.

Guy's Hospital Dental Society.

THE 19th Annual General Meeting was held on Friday, May 30th. The Hon. Secretary read the yearly report, which was approved. The following officers were elected for the ensuing session:—President, Mr. F. N. Doubleday; Vice-Presidents, Mr. R. Wynne Rouw, Mr. Montagu Hopson, Mr. J. Lewin Payne, Mr. E. B. Dowsett, Mr. E. C. Hughes, Mr. H. P. Aubrey; Hon. Secretary, H. Millett; Dental Correspondent, A. Bulleid; Committee, B. Underwood, D. A. Bevis, J. Stirling Hill, C. H. Laver.

A cordial vote of thanks to Mr. E. B. Dowsett was proposed by B. Underwood, seconded by W. A. Bulleid, and carried with enthusiasm.

GUY NEELY,
Hon. Sec.

Guy's '89 Club.

THE Eighteenth Annual Meeting and Dinner was held on the 14th May, 1913, at the Hotel Cecil, Major H. Hewetson, R.A.M.C., in the chair. There were also present H. W. Beach, E. F. H. Hardenberg, R. H. Hayes, W. G. Mumford, F. J. Steward, John R. Steinhaeuser, C. E. Carpmael, C. E. Michael, R. H. Fagge, H. M. Stewart, C. H. Fagge, G. S. Hovenden, H. W. Collier, W. E. Robinson, A. A. H. Partridge, and H. J. Spon.

Letters or telegrams of regret for non-attendance were received from O. Beven, C. H. Bryant, A. V. Clarke, R. F. Clark, R.N., W. W. B. Davies, L. Every-Clayton, C. D. Edwards, F. A. Godson, H. S. Hinton, B. Instone, T. L. Jackson, W. H. Jewell, M. A. Key, H. A. Moffatt (Cape Town), J. Moore, F. J. Nicholls, E. A. Peters, B. G. Reynolds, B. A. Richmond, A. Scott-Turner, E. T. Shorland, W. A. L. Smith, E. C. Taylor, P. N. Vellacott (Bloemfontein), and J. C. Wilkins.

It was decided to hold the Nineteenth Meeting at the Hotel Cecil on May 13th, 1914, and R. H. Fagge was elected President for the year.

Lawn Tennis.

GUY'S v. LONDON.

INTER-HOSPITAL CUP.—FIRST ROUND.

This encounter was won by Guy's, by 8 matches to 1.

SINGLES.

W. R. Reynell beat L. Powell	6–4, 6–2.
L. A. Graham beat T. B. Batchelor	6–1, 6–1.
H. Sharpe beat W. C. Hartgill	6–1, 8–6.
R. Curle beat W. H. Cam	6–2, 6–2.
R. H. Lucas beat L. C. Somervell	6–1, 6–1.
R. Montocchio lost to L. Clive Smith	6–3, 5–7, 6–0.

DOUBLES.

Reynell and Curle beat Powell and Cam ...	6–3, 6–1.
Sharpe and Graham beat Batchelor and Hartgill	6–4, 6–1.
Lucas and Montocchio beat Clive Smith and Somervell	6–2, 6–3.

Cricket.

At a meeting of "Blues," held on April 15th, the following officers were elected for the ensuing season:—Captain 1st XI., A. H. Harkness; Hon. Sec., B. Sampson. Captain 2nd XI., J. T. T. Forbes; vice-captain, C. C. Gibson. Committee: A. F. Rook, A. B. Bond, A. C. Hancock, F. J. Biddle, C. Vincent-Brown.

We are pleased to note that the 1st XI. have to date won five out of seven games. They gained their victories against Darenth Asylum, Sevenoaks, Hampstead, Granville, and Sutton.

GUY'S v. BECKENHAM

Played at Beckenham on Saturday, May 3rd.

BECKENHAM.

C. J. Hurst, b Sterne-Howitt	43
P. J. Aste, b Sampson	10
H. Z. Baker, b Biddle	7
W. A. Powell, lbw, b Harkness	35
J. K. Stenning, b Biddle	4
B. V. Stenning, b Harkness	5
F. Furze, b Biddle	0
M. E. Beall, c & b Harkness	5
R. Curwen, b Sampson	33
A. A. Torrens, not out	16
V. C. Loury, b Sterne-Howitt	8
Extras	7
Total	173

GUY'S.

A. H. Birks, b Torrens	9
A. B. Bond, b Torrens	21
C. Vincent-Brown, b Baker	0
H. Sterne-Howitt, c Curwen, b Powell	8
B. Sampson, b Torrens	4
L. R. Broster, b Torrens	0
F. Biddle, b Baker	0
C. L. Green, st Furze, b Torrens	29
A. H. Harkness, b Powell	2
F. Coombes, not out	0
J. T. T. Forbes, b Torrens	0
Extras	4
Total	77

GUY'S v. DARENTH ASYLUM.

Played at Dartford on Wednesday, May 7th.

GUY'S.

A. B. Bond, st Brown, b May	42
— Harris, c Barham, b Draper	1
C. C. Gibson, b Barham	0
C. L. Curle, b Barham	4
D. H. Dixon, b Templeman	0
F. Biddle, b May	20
B. Sampson, c Boyd, b Templeman	11
A. H. Harkness, b Templeman	5
T. W. Sheldon, b Templeman	1
R. V. Cookes, b May	1
H. J. Small, not out	0
Extras	7
Total	92

DARENTH.

H. Draper, c Sampson, b Harris	1
F. May, c Biddle, b Harris	20
L. Barham, c Biddle, b Harris	1
H. Sarginson, c Curle, b Harkness	0
M. Brown, c Sampson, b Biddle	12
F. Crancher, b Biddle	1
J. B. Palmer, not out	3
H. Spensley, hit wkt, b Harris	0
F. Boyd, b Harris	1
W. Templeman, c Bond, b Biddle	1
N. Butters, run out	1
Extras	7
Total	48

GUY'S v. SEVENOAKS.

Played at Honor Oak Park on Saturday, May 10th.

GUY'S.

A. B. Bond, c Grose, b Norman	45
H. Sterne-Howitt, b Lovett	13
C. Vincent-Brown, lbw, b Lovett	56
F. Biddle, b Norman	6
L. Green, c Escombe, b Norman	12
G. W. M. Andrew, lbw, b Norman	7
B. Sampson, c Richardson, b Grayley	6
A. F. Rook, c Cater, b Norman	8
L. R. Broster, b Norman	5
A. H. Harkness, b Grayley	3
T. W. Sheldon, not out	2
Extras	9
Total	172

SEVENOAKS.

T. A. Grose, b Sampson	1
C. L. Norman, b Sampson	12
J. S. Richardson, b Biddle	1
H. T. Cross, b Biddle	4
— Grayley, c Harkness, b Sampson	1
F. C. Lovett, b Biddle	0
H. Bligh, b Biddle	1
R. Escombe, not out	16
E. Horncastle, b Sampson	1
H. I. Turner, c Broster, b Sampson	0
H. W. Cater, ct Bond, b Sheldon	10
Extras	6
Total	53

GUY'S v. CROFTON PARK.

Played at Honor Oak Park on Monday, May 12th.

CROFTON PARK.

E. Glass, b Biddle	14
L. Davis, lbw, b Sampson	7
A. L. Cox, c Andrew, b Harris	1
A. R. Partridge, b Harris	17
B. Knight, run out	0
W. Hanna, b Harkness	7
H. S. Pearson, b Harris	7
H. J. Tutt, lbw, b Harris	0
A. E. Tuck, st Broster, b Harris	0
G. Gooch, b Harkness	3
C. W. J. Lepper, not out	1
Extras	3
Total	60

GUY'S.

G. W. M. Andrew, c Pearson, b Tutt	4
— Harris, c Partridge, b Tutt	3
C. Vincent-Brown, b Cox	5
A. F. Rook, b Tutt	14
B. Sampson, b Tutt	11
L. R. Broster, st Lepper, b Tutt	0
L. Green, b Tutt	1
F. Biddle, run out	0
T. W. Sheldon, not out	1
A. H. Harkness, b Cox	1
A. S. Liebson, b Cox	1
Extras	1
Total	42

GUY'S v. HAMPSTEAD.

Played at Honor Oak Park on Wednesday, May 14th.

GUY'S.

A. B. Bond, c Everett, b Burns	33
A. C. Hancock, lbw, b Hyde	22
C. Vincent-Brown, lbw, b Hale	32
G. W. M. Andrew, c Everett, b Burns	2
F. Biddle, st Hodgson, b Burns	1
L. R. Broster, b Burns	7
B. Sampson, c Hodgson, b Burns	11
A. H. Harkness, b Hale	10
G. Noott, b Burns	0
T. W. Sheldon, not out	2
R. V. Cookes, b Burns	3
Extras	4
Total	127

HAMPSTEAD.

T. H. Farmiloe, b Andrew	14
R. S. Everitt, c Harkness, b Sheldon	31
G. F. Farmiloe, b Andrew	1
G. M. Hodgson, lbw, b Andrew	5
W. T. Hale, c Hancock, b Harkness	11
— Burns, lbw, b Biddle	3
K. C. Allen, not out	5
F. Atkins, lbw, b Biddle	2
— Hyde, b Biddle	4
Extras	20
Total	96

GUY'S v. GRANVILLE.

Played at Honor Oak Park on Saturday, May 17th.

GUY'S.

A. B. Bond, b Downey	51
A. C. Hancock, c Fryshe, b Brymer	2
C. Vincent-Brown, st Dickens, b Johnstone	76
G. W. M. Andrew, b Downey	12
A. F. Rook, c Lincoln, b Fryshe	88
C. Curle, b Johnstone	0
T. W. Sheldon, c Brymer, b Downey	1
H. Sterne-Howitt, c King, b Farquhar	5
A. H. Harkness, b Farquhar	5
L. R. Broster, b Lincoln	5
F. Biddle, not out	0
Extras	8
Total	253

GRANVILLE.

S. Platt, b Andrew	4
A. S. Johnstone, b Andrew	3
F. Odell, ct Bond, b Biddle	36
E. A. Brymer, c Sterne-Howitt, b Andrew	10
P. P. Lincoln, b Sterne-Howitt	7
H. A. Dickens, b Sterne-Howitt	7
E. Downey, c Vincent-Brown, b Harkness	14
J. Farquhar, b Harkness	29
C. E. Fryshe, b Sterne-Howitt	1
C. Downey, st Bond, b Sterne-Howitt	8
— King, not out	6
Extras	3
Total	128

GUY'S v. SUTTON.

Played at Honor Oak Park on Wednesday, May 21st.

SUTTON.

A. B. Read, c Sampson, b Biddle	19
A. K. Hickman, c Bond, b Biddle	15
A. Butt, c Biddle, b Sampson	4
D. D. Napper, lbw, b Sampson	4
J. M. Williamson, c Bond, b Biddle	7
V. R. Bromage, c Hancock, b Biddle	14
R. M. Bell, b Biddle	17
H. Lacey, c Bond, b Biddle	0
R. H. Clark, c Sampson, b Biddle	9
D. Eglington, not out	11
R. H. Lucas, b Biddle	2
Extras	7
Total	109

GUY'S.

A. B .Bond, st Clark, b Napper	7
A. C. Hancock, b Bell	14
C. Vincent-Brown, b Bell	0
A. C. Birks, b Bell	21
G. W. M. Andrew, lbw, b Napper	5
D. H. Dixon, b Napper	0
L. Green, b Bell	0
B. Sampson, b Bell	22
F. J. Biddle, b Napper	5
A. H. Harkness, c Napper, b Bell	44
G. Noott, not out	8
Extras	7
Total	133

Births.

EWING.—On May 15th, at the Moat, Puckeridge, Herts, to Dr. and Mrs. A. W. Ewing, a son.

TA'BOIS.—On May 11th, at Wickham Road, S. John's, S.E., the wife of L. Ta'Bois, L.D.S., of a daughter.

Death.

KERBY.—On May 14th, at Ivy House, Newbury, Robert John Kerby, M.D., in his 59th year.

G. T. M.

GUY'S HOSPITAL GAZETTE.

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Obituary.

JAMES HENRY TARGETT,
M.S., F.R.C.S.

FOR the second time we have to chronicle and with deep sorrow the death while still on the active Staff, of another of our gynæcological teachers. It is but a short time since Dr. Horrocks passed away, and now we mourn the loss of Mr. Targett, taken all too soon from a sphere of great usefulness. In his premature death we lose the services of an experienced teacher, and one who was always ready to help those who asked of him; the Hospital loses one whose ripe experience and wide pathological knowledge cannot easily be replaced; the profession one who was already recognised as a leading opinionist and a skilful operator. Guy's men had come to recognise his sterling merits, his unfailing courtesy, and the value of his opinion in difficult cases. While progressive, he was wise in delay, urging operation where the issue was clear, while on the other hand advising delay where recovery was possible otherwise.

Mr. Targett was born near Salisbury in Wiltshire. He was educated partly at the grammar school at Warminster, but being by no means in strong health, was placed under a tutor in Salisbury. He had already matriculated at the London University when he entered Guy's Hospital in October, 1878. Obtaining honours in anatomy and chemistry at the first M.B. in 1881, he took the M.B. in 1883 with honours in forensic medicine, and in the same year was awarded the Mackenzie Bacon prize in ophthalmology, and was bracketed equal for the Gurney Hoare Prize. Having filled the positions of house physician and house surgeon, and taken the degree of Bachelor of Surgery with honours in 1885, he was appointed surgical registrar for two years, and while holding this appointment he obtained the Fellowship of the Royal College of Surgeons of England. Having taken the Mastership in Surgery in 1887, he was, in the same year, appointed assistant curator of the museum at Guy's Hospital, and the next year pathological assistant at the College of Surgeons, and after two years pathological curator. This latter post he held for seven years, so that he served the College for nine years. While holding this appointment he was elected a demonstrator of anatomy at Guy's Hospital, and continued to teach in this department for six years. With these appointments he also discharged the duties of assistant surgeon to the Evelina Hospital for Children. From 1895 he taught practical surgery and morbid histology until 1897, when he was appointed obstetric registrar and tutor, and in the following year assistant obstetric physician. He held this post for five years, and combined that of surgeon to out-patients to the Samaritan Free Hospital for Women. To qualify himself further for his work he spent a good deal of time at Queen Charlotte's Hospital, and on the retirement of Dr. Galabin, in 1903, Targett was promoted to the full position of gynæcological surgeon to Guy's Hospital, sharing these duties with the late Dr. Horrocks.

The soundness of his work had become so much appreciated that he was offered, and accepted, the gynæcological position at the Bolingbroke Hospital, then coming into prominence, and also at St. John's, Lewisham. These three positions he continued to occupy at the time of his illness. While serving the College of Surgeons Targett delivered the Erasmus

Wilson lectures in 1893–94–95, and edited six appendices to the catalogue of the museum.

He was elected a Fellow of the Obstetrical Society in 1891, and made some 25 contributions to the Transactions in the next six years, and here his wide pathological knowledge was of conspicuous service. Amongst other communications may be mentioned the article in Quain's Dictionary of Medicine on "Diseases of the Fallopian Tubes," papers in the Guy's Hospital Reports, and numerous papers and reports in the Transactions of the Pathological Society. From 1901–06, and again from 1908 to the time of his illness, he was an examiner in midwifery at the Conjoint Board, and from 1900–02 served on the Board of Examiners for Midwives. In 1910–11 Mr. Targett was joint secretary of the Obstetric and Gynæcological Section of the Royal Society of Medicine. From the foundation of the Clinical Research Association up to three or four years ago Targett examined the morbid growths, writing out all the reports himself. This work never ended and occupied much of his evenings, so that he allowed himself little relaxation from work. Such is a brief summary of the public work of this busy life, and when there are added the demands of a rapidly increasing practice the strain upon anything but a strong physique will be appreciated.

To write of one who filled so many positions in the Hospital and School would be impossible. Those who studied anatomy under him in the early years, are now well established in life, and the same remark applies to those to whom he taught pathology and surgical diagnosis while he was Surgical Registrar. From some of these old students we have heard of his unflagging patience, his clear exposition, and his encouraging appreciation while they struggled with the details of anatomy; while others have spoken of the pathological and histological classes as being of the greatest service.

It is with the Gynæcological Department, however, and with this branch of medicine that his name will be most closely associated, and it is here that we best knew him.

It was only when talking intimately and quietly to one or two that Mr. Targett gave of his best. His shyness and retiring disposition prevented him from doing himself justice before a class. He spoke in a low tone, and it was diffioult to gather what he said. He was averse to laying down the law. He delighted in coming at odd times and wandering round the wards, attended by the sister, chatting to the patients. No circumstance was so small that it was overlooked, no difficulty so great but it must be surmounted. "It was not," writes one, "until we became Residents that we realized all he was to his patients. and to those who worked for him. Closer contact revealed his great kindness and sympathy, and brought him that popularity that deepened to greater admiration as they knew him better."

Another, and recent Obstetric Resident speaks of the care he took in supervising the reports, adding the essential points very often himself, and of the informal demonstrations he gave after operations on the parts removed.

He certainly was, as an operator, an example of carefulness in detail. Slow he may have been, but he was sure, and the success that attended his work was of the highest. He was one of the men from whom we learn by seeing his work, and we know that there are those who teach in this way, while others teach by questions and explanations. The few gain much from such teachers, while it must be acknowledged, that the many suffer. Both varieties are of service, and in their different ways, promote learning.

We always thought Mr. Targett looked overworked and often tired, and no doubt his attack of appendicitis left its mark on a frame never robust. He had a striking face and head, the shadows were deep on his finely-cut features, and as he crossed the colonnade in the fewest possible number of strides intent upon the work in hand, giving but a brief salutation, and that hardly with a smile, many would think him austere and even ungracious. But it was really shyness of a kind, for, reaching his wards, all this would disappear, and the sympathy of the real man with the patients came out and illuminated those dark shadows and turned all into sunlight.

Some men, no doubt, take life too seriously toil in their work, giving an impression that the burden is too heavy. Such an impression Mr. Targett would give the younger man, but those of us who knew him in his wards saw much of the bright side of his character He knew each patient, went so fully into every detail, entered into the fears and anxieties of those under his care, that they felt nothing was forgotten, and no hasty judgment had been formed. It was the same, we have been told, with his private consultations, as one remarked to us, "One sent cases with the feeling that they would come back quite satisfied that every consideration had been shown them."

How difficult is it to judge when one sees only part of a character, and how easy to misjudge.

"Thus drifting afar to the dim-vaulted caves
Where life and its ventures are laid,
The dreamers who gaze while we battle the waves
May see us in sunshine or shade;
Yet true to our course, though our shadow grow dark,
We'll trim our broad sail as before,
And stand by the rudder that governs the bark,
Nor ask how we look from the shore!"

Those who knew him could not but mark the effect of the blow that fell upon him in the winter of 1911, when he lost his only child. He looked thinner, the shadows grew deeper, and he moved with even a more set purpose. He said, indeed, to a friend that he must work harder and was blessed in having plenty to do. The boy's loss was keenly felt, for with great care he had reached the age of seventeen, and was a bright lovable fellow and a companion to his father, especially in the summer holidays. Mr. Targett had even taken lessons with his son in golf, and was planning a holiday on the coast to enjoy the game.

His private practice had increased rapidly among Guy's men, partly owing to the retirement and death of those senior to him, but chiefly to the soundness of his opinion and the excellence of his operative skill. He was, in fact, closing his hand upon one of the most important positions in London, which would have brought him position, esteem, and wealth.

During the early part of his long illness, and, indeed, up to March, he frequently spoke of his desire to "do some more work for Guy's." It was extraordinary how often he said this; no other thought appeared to dim this desire. When hemiplegia came, he said with suppressed emotion, and in a quiet tone of resignation, "I cannot do any more for Guy's now." Then he began to talk of the future of his department, all that might be done, and who would carry on the work.

It was a long and at times very painful illness, met at every turn by the constant attendance and devoted thoughtfulness of Dr. Frederick Taylor, associated from time to time with help from other friends. It is not for us to comment upon that illness, sufficient that he died from ulcerated endocarditis, that he bore the illness with great fortitude, never resented the blow, and when the hemiplegia came and he knew all usefulness was over he then wished to be "taken home."

James Henry Targett.

An Appreciation.

THE early death of James Henry Targett comes as a great loss to Guy's and the profession, no less than to his patients and friends.

Guy's knows with what whole-hearted devotion, until laid aside by illness, he carried on the work of his department, never sparing himself in the wards nor at out-patients'.

His wonderful diagnostic skill, based upon large experience and a well-trained mind, was widely acknowledged and appreciated.

As an operator he was safe and painstaking, the interest of the patient being his sole consideration.

Targett was an ornament to the profession, who regarded him as a sound, level-headed Surgeon and Gynæcologist, one whose opinion they valued and acted upon, and who as a Pathologist stood unrivalled.

Patients instinctively felt confidence in him, his quiet, earnest manner carrying conviction. Upon several occasions, and once to the writer himself (who practises another speciality), Targett, because he knew the patient, voluntarily acted as a dresser in a private surgical case. The writer, a friend of twenty-four years' standing, always found great pleasure in his company. There was an entire absence of self-interest and self-praise, and as showing a noble character he never remembers Targett to have uttered an unkind word about anyone. His gentle manner and simple unworldly life endeared him to all with whom he came in contact, and even in his last illness the bed-side chats with him were invariably cheery and inspiriting. His love for others was truly Christian, and his life should prove a noble example of unselfishness.

"His life was gentle; and the elements
So mixed in him, that Nature might stand up
And say to all the world, *this was a man!*"

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COMPILED BY WM. WALE, Wills Librarian.

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Obituary.

H. I. JANMAHOMED, M.D., F.R.C.S.

WE deeply regret to have to chronicle the death of Habiburia Ismail Janmahomed, which took place on Saturday, June 7th, at the National Liberal Club. His death deprives the medical profession not only of India, where he practised, but also of this country, of a man who had already given promise of a brilliance which is but rarely shown. In him Guy's loses not only one of the most brilliant of her alumni in recent years, but a man who was sincerely beloved and respected by all who came in contact with him, both for his charming personality and his equally charming modesty. Since he left the hospital he has been in practice in Bombay, where his father practised before him, and only returned to this country on account of his health. His death was caused by diabetes.

Janmahomed entered the hospital in October, 1903, and obtained the M.B., B.S. (Lond.) with Honours in Medicine in 1908, and the Conjoint Diploma a little earlier. He won the Treasurer's Gold Medal in Clinical Medicine in 1909, and was awarded a certificate at the examination for the Golding Bird Medal in Bacteriology in the same year. It was also in 1909 that he passed the M.D. (Lond.) in Medicine, and was awarded the University Medal. In 1911 he became a Fellow of the Royal College of Surgeons. Before leaving the hospital he did Clinical Assistant, and was also for a time Clinical Assistant at Evelina Hospital for Children. He was joint author with Dr. Hale White of a treatise on "Frequent Failure of Urine to Decompose in Cases of Pulmonary Tuberculosis," in the *Quarterly Journal of Medicine* in 1909.

Gazette Special Pathologist.

J. F. R., BIRMINGHAM.—This is a condition of chronic mastitis in which the breast tissue is indurated and the ducts and acini are dilated and filled with catarrhal products. There is no duct papilloma to be found, and there is no evidence of a malignant growth.

PATHOLOGIST.

Passim.

THE new posts of Chemical Pathologist and Morbid Histologist to the Hospital, to which we drew attention in a recent issue of the GAZETTE, are the outcome of a desire long felt by the Authorities for a more rational and more scientific scheme for the investigation of disease and the prosecution of research. At the present time research work is being carried out in various departments, where individual investigations are pursued from one point of view only, and with no reference to the varied aspects from which other departments might approach the same subjects. This state of affairs has, of course, the great disadvantage that a comprehensive investigation into any disease from all its clinical and pathological aspects is almost impossible on account of the difficulty of marshalling the numerous independent workers into line and the still greater difficulty of keeping them there. This defect, which is common to all centres for research in this country, depends, of course, on the fact that the various laboratories are to all practical purposes independent of one another and no efficient means exists for systematizing their efforts and directing them to a common end. In the German Universities, on the other hand, as is well known, a means has been found to obtain this control in the system by which the Professor is supreme and has under his direction a staff of assistants capable of pursuing a given investigation in all its aspects. This system, however, in spite of its obvious advantages, is open to the objection that the work of individuals is of less value than the spontaneous observations of an independent worker. Apart, however, from theoretical objections, the practical difficulties which lie in the way of any attempt to replace our present system by the German method are such as to make it very unlikely the experiment will be made in this country, at any rate in the near future. At the same time it should be possible by some system of closer communication between the different workers to prevent much of the waste of energy which now goes on.

As soon as attention is directed to the methods at present in being in the Hospital, it becomes obvious that much of the work is totally valueless from a scientific point of view, since it is done by untrained observers without any adequate supervision. Investigations in the Clinical or other Laboratories, carried out by Ward Clerks, may be very valuable as experience to the individual, but he would be the first to admit that they are seldom sufficiently reliable to be of any scientific value at all. It was the recognition of this fact which led the authorities to create the new posts of Clinical Pathologist, and Morbid Histologist.

The Chemical Pathologist will in future be responsible for the examination of gastric contents, sputa, urines, etc., which may be sent down from the wards, and will work in the old Gordon Laboratory, which is now vacant since the building of the new Pathological Department. Whilst the new Department will be responsible for the final report on the specimens sent down, there is, of course, no intention of depriving the clerks of all the necessary experience in carrying out these very essential investigations. They will, on the contrary, have the advantage of systematic teaching from the Chemical Pathologist, in addition to help from the Registrars as at present.

The Morbid Histologist, who is to work in the small laboratory near the new operating theatres, and in the annexe to the post-mortem room, will be responsible for the examination of all the pathological specimens removed at operation, and for blood films. Here again, of course, the clerks will have the advantage of systematic teaching in addition to their practical experience.

WE have to chronicle yet still further evidence of the strenuous endeavours the Authorities are making in order to make the School second to none, not only in its buildings and equipment—that has been done as we all know—but also in the teaching of all the various branches of the medical curriculum. It has been decided to establish a Lectureship in Pharmacology, so that systematic lectures in this subject may be given by a man who is devoting his whole time to experimental pharmacology. The realisation of this project is largely possible through the

generosity of the Hon. Mr. Greville, who has endowed the Lectureship to the extent of £200 a year, and thus relieved the School of the difficulty of providing two-thirds of the necessary salary. The new lecturer will be accommodated in one of the laboratories of the new Pathological Department. In addition to the lectures in Pharmacology, there will be, as heretofore, lectures in Therapeutics, and Materia Medica.

THE salary of the new Lecturer will be £300 per annum, and he will be required to enter upon his duties on 1st October, 1913. Any further particulars may be obtained from the Dean of the Medical School. Candidates are requested to send twenty copies of their application and of not more than three recent testimonials to the Treasurer, Superintendent's Office, Guy's Hospital, S.E., not later than 5th July, 1913.

WE have great pleasure in announcing that the Degree of Sc.D. (Cambridge), has been conferred on Mr. R. Assheton, the Lecturer in Biology.

OUR Cricket Team were very unfortunate this year in falling before St. Thomas's in the semi-final round of the Inter-Hospital Cup on June 11th at Winchmore Hill. St. Thomas's batted first, and our men felt very pleased at getting them all out for 116; their joy was, however, very short-lived, as seven wickets quickly fell for 41, and the whole side was out for 83. Our failure is all the more inexplicable in that the side is on paper a strong batting one, and was confidently expected to give a good account of itself. However, there is no good in crying over spilt milk. Better luck next year!

THE Annual Swimming Sports will take place on Thursday, June 26th, in the Southwark Baths, at 7.45 p.m. The events will include a display of diving by the Highgate Life Buoys, a Nurses' Race, 60 yards Hospital Championship, Breast Stroke Hospital Championship, Full Clothes Race, Plunge and Diving, Ladies' Diving Competition, and a Water-Polo Match (Past v. Present). This entertainment has been in recent years one of the chief successes among the hospital sports, and it is confidently expected that it will not be less successful and enjoyable this year. The Swimming Club is making an extra effort to recapture the Inter-Hospital Swimming and Water-Polo Cups, neither of which we now hold. May all success attend their efforts.

THE Inter-Hospital Athletic Sports will take place at the Stamford Bridge Ground on Tuesday, June 24th. It is to be hoped that as many men as possible will turn up to cheer our representatives on, and, perhaps, help them to do better than in the last few years, and return home with the Inter-Hospital Shield. We make this appeal in the hope of stimulating men to turn up in force, but we are not very hopeful of producing much result in view of the small attendance at the Hospital Sports on June 7th. We are sure that if men realised how much encouragement it gives competitors to be cheered on by their supporters they would, if only for the honour of the School, turn out in much larger numbers.

AT the recent Conference of the National Council of Trained Nurses of Great Britain and Ireland, held in Dublin early in June, Miss L. V. Haughton, our Matron, read a paper on the "Preliminary Training of Probationers." Miss Haughton pointed out how important it was in view of the increasing demands made upon the education and intelligence of nurses by the growing complexity of medical and surgical treatment, that there should be some minimum standard of ability exacted of women before they were allowed to take up nursing. The question is in many ways analogous to the problem of the preliminary examinations in general education which the General Medical Council insist upon for medical students, and is one upon which we imagine there is fairly general agreement.

A mere male, perhaps, may be allowed to ask why so many nurses seem to look back upon their stay in the "School" with so much dislike. Is it because they are at first more intolerant of that yoke of obedience which is riveted

so firmly on them, but to which they later become inured?

IT is not often, one suspects, that patients have as long memories for benefits received as the case reported in our columns this week by Sister Naaman. One could hardly expect anything else, seeing that it is in the nature of us poor "humans" to be ever more mindful of present discomforts than of past benefits. Therefore, we take off our hats to the anonymous donor and offer him our respect and our thanks. To those of us who are of the present generation it sometimes seems difficult to realise that patients of as long ago as 1884 had much to be grateful for. The traditions that come down to us from our seniors are all lurid tales of sepsis and bad surgery, with scarcely ever a word of the good work that was done. No doubt this is because they know well that we have little or no interest in the best surgery of the past, but thirst only for the "horrors" of the old frock-coats and similar thrills.

WE have received a copy of a very interesting paper, read before the Hunterian Society of St George's Hospital, by Sir Charles E. H. Chadwyck-Healey, K.C.B., on the Medical Reserve of the Navy. Special attention is directed to the Royal Naval Volunteer Medical Reserve. The conditions of this service are somewhat similar to the analagous reserve of medical officers for the Territorial Force. Candidates sign on eight years, and during that time must go to sea twice for training for 14 to 28 days, and must put in two 14-day courses at a Naval Hospital. At the end of that period they are eligible for promotion to the rank of Staff-Surgeons, and after a further period of eight years for advancement to Fleet-Surgeons. On joining the service, officers receive an allowance of £20 for uniform, and are paid at the rate of 14s. to 18s. per diem during training, together with any other allowances due to officers on the active list. The Reserve offers very distinct advantages to any men who are anxious to be of service to the Navy in time of need, and is well worthy of further enquiry and consideration. Copies of Sir Charles Chadwyck-Healey's paper may be obtained at the Medical School Office.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—ED., G.H.G.]

DEAR SIR,—At the last meeting of the Rhodesian Branch of the British Medical Association I brought forward the case of Shingles followed by Chicken-pox, an account of which appeared in the GAZETTE of April 26th. This had the desired result of putting members on the *qui vive* for similar cases, and Dr. R. W. Jameson kindly put me in communication with a patient of his own who had suffered from herpes zoster of the intercostal variety, and whose infant, aged 5½ months, showed a chicken-pox eruption fifteen days later. The case is very similar to that you have already been good enough to report.

The mother is the wife of a missionary living sixty miles from a railway station. The hepatic eruption appeared on March 25th, and was preceded by three days' and followed by seven days' neuralgic pain, causing sleepless nights. The chicken-pox rash appeared on the child on April 9th, giving fifteen days as the incubation period. The parents assure me that to the best of their knowledge there was no possibility of contact with any case of chicken-pox. The mother had chicken-pox when a child of seven, but had never previously had shingles. The only common factor worthy of note seems to me to be that of close contact.

In the first case the elder girl slept with her mother, and in the second place, from the age of the child, the contact must naturally have been still closer. I cannot help thinking that when once the attention of practitioners is attracted to the possibility of a connection between the two diseases, quite a number of similar cases may come to light, especially in the practice of country members, where the source of infection is easier to trace.—Yours, etc.,

W. P. Le FEUVRE.

P.S.—May I draw attention to a misprint in my quotation from Adamson on page 175 of the GAZETTE? "*Occurrence*" should be "*recurrence*."

DEAR SIR,—On Sunday, 1st June, a working man was walking round Naaman ward and was asked what he wanted. He replied that in 1884 he had been a patient in the ward with a bad knee, and felt he must come in and look round. When he had gone, a note of thanks and blessing to the hospital, with 2s., was left by him on the ward table. SISTER NAAMAN.

SIR,—As the mother of one of your men, who is permitted a peep at the doings of the Gods in your interesting monthly, will you let me say how I echo your words in

last PASSIM. You say "It is a constant source of regret to us, that practically all the higher posts in the nursing profession are distinguished as administrative and not nursing posts." So say the nurses themselves.

A niece, who qualified in another of your large hospitals, was offered a Matronship on completion of her term of four years. Instead, she became a Queen's Nurse in Cambridge, explaining to me—"I really didn't want to degenerate into a mere *housekeeper*; I love my work!" Surely there must be a solution!—I am, yours faithfully,

ERICA.

The Milward Fund.

FOURTH LIST OF SUBSCRIPTIONS FROM GUY'S MEN.

	£	s.	d.
Amounts already acknowledged	132	17	0
E. J. H. Budge, Cadoxton	2	2	0
W. W. David, Pontypridd	3	3	0
W. Norwood East, London	1	1	0
E. Goodall, Cardiff	5	5	0
John Hewell, Cheltenham	1	1	0
Charles Jephcott, Chester	1	1	0
Thos. John, Swansea	0	10	6
W. J. Lindsay, London	2	2	0
"M"	2	2	0
T. Brice Poole, Westcliff-on-Sea	2	2	0
Hubert J. Starling, Norwich	2	2	0
J. R. Steinhaeuser, Lewis	1	1	0
W. H. M. Telling, Leeds	2	2	0
W. Hale White, London	3	3	0
W. K. Wills, Bristol	1	1	0

Particulars of the Fund can be seen in the GAZETTE of May 10th.

Further Donations will be gratefully received by the Hon. Treasurer, Mr. William Sheen, 2, St. Andrew's Crescent, Cardiff.

Golf.

A Summer Meeting open to the Staff and Students will be held on Wednesday, July 23rd, at Sundridge Park, when the following events (without entrance fee) can be played for.

1. In the Morning—A Handicap Bogey Competition.

2. In the Afternoon—An 18 holes Handicap Medal Competition, with this a prize will be given for the best scratch gross score.

Prizes will be given and there will be an optional 2s. 6d. sweepstake in each handicap event.

All entries with competitors lowest club handicap (naming club) must be sent to the Hon. Sec., R. Curle, by Monday, July 21st. Competitors should please try to arrange their own opponents if possible.

Nursing News.

To celebrate the opening of the Nurses' New Tennis Court, a Garden Party was held at The Cottage, Honor Oak Park, on Wednesday, May 21st. Among those present were, Mrs. Cosmo Bonsor, President of the Nurses' League; Miss Swift, Vice-President; Mrs. Fagge, Hon. Treasurer; Lady Perry, Mrs. Shaw, and many other Hon. Members of the League.

The event of the afternoon was a match played on the new court, between "Mrs. Fagge's Team," and the Nurses, which resulted in a victory to Mrs. Fagge of eight games. Six events, of nine games each, were played.

Mrs. Mollison and Mrs. Houseman beat Sister Doris and Nurse Raben ... ... 7–2.
Mrs. Witham and the Hon. Miss Bingham beat Nurse Ryan and Nurse Rowan ... ... 6–3.
Mrs. Shaw and Mrs. Forsyth lost to Nurse Knight-Law and Nurse Sadlier ... ... 4–5.
Mrs. Mollison and Mrs. Houseman beat Nurse Ryan and Nurse Rowan ... ... 5–4.
Mrs. Witham and the Hon. Miss Bingham lost to Sister Doris and Nurse Raben ... ... 3–6.
Mrs. Shaw and Mrs. Forsyth beat Nurse Knight-Law and Nurse Sadlier ... ... 6–3.

The afternoon was beautifully fine, and tea was served during the match in the garden. The new court was voted a great success, and it is hoped that the Match will be made an annual event, when, I have heard "Mrs. Fagge's Team" are not going to be allowed even a look in.

GUY'S HOSPITAL v. THE NORTHERN HOSPITAL, WINCHMORE HILL.

The first round for the Challenge Cup was played on June 4th, at Winchmore Hill, and resulted in an easy win for Guy's.

Nurse Ryan and Nurse Rowan won their event ... ... 6–0, 6–2, 6–0.
Sister Doris and Nurse J. Fletcher won their event ... ... 6–1, 6–2, 6–0.

University of London Officers' Training Corps.

Medical Unit. "B" Section.

NOTICES.

1. The attention of cadets is particularly drawn to paragraph 2 of the orders for Saturday, June 21st, which runs thus:—

> "Cadets are reminded that attendance at the Annual Inspection is compulsory for efficiency, and that leave can only be granted on medical certificate or for special reasons. Applications for leave should be made through O.-C. Section, and must be received prior to date of Inspection."

2. Cadets are warned that no application for leave can be considered which is not received by me on or before Wednesday, June 25th, and that no one will come to camp who is rendered inefficient by not attending Inspection without leave.

T. B. LAYTON,
Lieut., R.A.M.C. (T.),
O.-C. "B" Section.

Appointments.

Medical School Appointments.

JULY—SEPTEMBER, 1913.

Clinical Assistants.—Messrs. H. W. Evans, E. M. Mahon, C. H. G. Pochin, A. C. Clifford, E. S. Taylor, A. J. E. Smith.

Clinical Assistants in Medical Wards.—Messrs. F. V. Bevan Brown, J. F. Venables (Dr. Hale White); S. Wilson, C. F. Pedley (Dr. Pitt); C. H. Gould, F. D. Annesley (Sir Cooper Perry); A. J. Drew, W. R. Pryn (Dr. Shaw).

Clinical Assistants in Surgical Wards.—Messrs. R. P. Ninnis (Sir Alfred Fripp); C. S. L. Roberts (Mr. Steward).

Dressers in Special Departments:—

Throat and Ear, Children, Genito-Urinary.—Messrs. A. Tilbury, P. D. Scott, J. A. Martin, N. Elliot.

Throat and Ear, Skin, Orthopædic.—Messrs. C. de W. Gibb, W. M. Lansdale, O. G. Parry-Price, H. L. P. Peregrine.

Eye, Nervous System.—Messrs. O. G. Parry-Jones, H. Mather, J. W. Kemp (Mr. Eason); R. Sells, J. York Moore (Mr. Ormond).

Obstetric Dressers and Externs.—Messrs. C. Sherris, D. C. Scott, C. R. Smith, D. R. Jones, T. R. Trounce, F. E. R. Laborda, H. G. Dresing, G. L. Attwater, W. D. Galloway, R. J. Hearn, D. MacManus.

Medical Ward Clerks and Post-mortem Clerks.—Messrs. C. H. Medlock, J. Stephenson, H. Q. F. Thompson, R. W. Cushing (Dr. Hale White); L. S. Fry, B. Sampson, W. H. Nicholls (Dr. Pitt); W. L. E. Reynolds, R. W. P. Jackson, H. F. T. Hogben, B. Burnside (Sir Cooper Perry); J. F. Mackenzie, K. Westman, A. K. Day-Lewis, R. Quesada (Dr. Shaw). G. Noott, J. G. Stevens, V. E. Lloyd, J. E. Clark, J. Kyle, C. W. W. Baxter, G. S. B. Long, J. Totton, R. M. Craig, M. J. T. Wallis.

Assistant Surgeons' Dressers.—Messrs. L. R. Broster, S. W. Coffin, C. C. G. Gibson, A. C. M. Coxon (Mr. Fagge); C. P. Symonds, E. J. Cooke, R. A Holmes, W. L. Partridge (Mr. Rowlands); J. F. H. Stallman, K. L. Bates, G. B. Tarring (Mr. Turner); R. Curle, G. D. Gripper, A. F. Rook, N. E. Kendall (Mr. Hughes); E. W. Bowell, W. A. Easton, M. Chadwick (Mr. Davies-Colley).

Surgical Ward Clerks.—Messrs. J. J. Canybeare, J. E. Jones, K. N. Purkis.

Surgeons' Dressers.—Messrs. W. A. Young, A. H. Harkness, J. H. Parry (Sir Arbuthnot Lane); H. L. Messenger, C. E. Petley, J. S. Cocks, J. E. Davies (Mr. Dunn); F. L. Spalding, D. O. Richards, L. R. Pickett (Sir Alfred Fripp); A. S. Liebson, L. Horsley, A. L. Anthony, L. A. J. Graham (Mr. Steward).

Naval and Military.

Promotion to be Fleet Surgeon: Staff-Surgeon R. F. Clark, R.N., dated 25th May, 1913.

Captain R. T. Collins, R.A.M.C., has been appointed Medical Officer in charge Military Hospital, Inverness.

Captain H. G. Gibson, R.A.M.C., has been appointed Medical Officer in charge Spike Island, Queenstown.

Captain H. C. Winckworth, R.A.M.C., has been appointed Specialist in Operative Surgery at the Royal Herbert Hospital, Woolwich.

Lieut. D. Reynolds, R.A.M.C., has embarked for Service abroad.

Civil.

W. S. Brown, M.R.C.S., L.S.A., has been appointed Visiting Medical Officer to Paramatta Gaol, New South Wales.

S. W. Daw, F.R.C.S., has been appointed Assistant Honorary Surgeon to the General Infirmary, Leeds.

E. L. Elliott, M.B., B.S., has been appointed District Medical Officer to Sevenoaks Union.

Herbert French, M.D. (Oxon.), F.R.C.P. (Lond.); Examiner in Medicine to the Society of Apothecaries, London.

H. J. Gater, L.M.S.S.A. Lond., L.M.R.C.P.I., has been appointed Clinical Assistant, Royal Ear Hospital, Soho, W.C., and Clinical Assistant to Evelina Hospital for Children, Southwark, S.E.

J. T. Smalley, M.R.C.S., L.D.S., has been appointed a Government Medical Officer, Hong Kong.

Change of Address.

J. H. Busteed, L.S.A., L.R.C.P. Edin., and L.R.C.S. Edin., from Stuart Lodge, Highcliffe-on-Sea, to Broad Street House, Bungay, Suffolk.

W. Archer Hodgson, L.D.S., from 255, Coldharbour Lane, Brixton, to "Eddington," 319, Brixton Road (corner of Villa Road), S.W.

C. H. Housden, L.D.S., from 9, Victoria Place, Eastbourne, to "Hatfield," Waterden Road, Guildford.

Bernard Isaacs, L.D.S., from Guy's Hospital, to 125, Petherton Road, Canonbury, N.

D. B. Morrish, L.D.S., from Guy's Hospital, to 46, Carson Road, Dulwich, S.E.

H. B. Neely, L.D.S., from Bromley, to 3, London Road, Southampton.

Graham Poock, L.D.S., to 33, High East Street, Dorchester.

H. N. Purdom, L.D.S., from Guy's Hospital, to 25, Park Hill Road, Croydon.

E. R. Saul, L.D,S., from Guy's Hospital, to "Woodmancott," Lymington, Hants.

J. T. Smalley, M.R.C.S., L.R.C.P., from D.M.O., Levuka, Ovalau, Fiji, to Colonial Medical Service, Hong Kong.

C. H. Stainer, L.D.S., from Guy's Hospital, to 22, Twyford Avenue, West Acton, W.

C. M. Stevenson, M.B., B.C. Cantab., from 237, to 90, Chesterton Road, Cambridge.

C. Doswell Wallace, L.D.S., to 12, Montague Place, Worthing.

Papers by Guy's Men.

D. Forsyth, M.D., D.Sc., F.R.C.P.: Breast Feeding; The Consumption of Breast Milk.—*Lancet*, 14th June, 1913.

F. W. Langridge, M.R.C.S., L.R.C.P.: Clinicalia.—*Clinical Journal*, 11th June, 1913.

Lawrie McGavin, F.R.C.S.: A Case of Swelling and Ulceration of the Tongue.—*Clinical Journal*, 11th June 1913.

Two Cases of Splenic Anæmia.

NOTES OF A CLINICAL LECTURE BY W. HALE WHITE.

Ethel W., aged 10, admitted in Mary, 22nd February, 1913. Patient is an only child. Parents and other relations all have good health. Has had measles, scarlet fever, pneumonia, and discharge from the ears. Has never been strong, and was brought to the hospital for general weakness.

On admission.—Is pale and thin, but not wasted. The heart, lungs, nervous system, and urine are healthy. The tongue is clean, gums pale, abdomen distended; liver palpable, but hardly enlarged. There is a tumour on the left side of the abdomen which has a notch on its anterior border, and is evidently an enlarged spleen. It reaches to within an inch of the anterior superior spine. No enlarged glands can be felt anywhere. Blood count shows:—Red cells, 5,075,000; white cells, 5,313; per cent. of hæmoglobin, 55; colour index, 0·48. Differential white count: Polymorphs, 61·22 per cent.; small lymphocytes, 12·24 per cent.; large lymphocytes, 9·52 per cent.; hyaline lymphocytes, 15·64 per cent.; eosinophiles 1·35 per cent.

A diagnosis of splenic anæmia was made. Iron and arsenic were prescribed, and X-rays were applied over the spleen. The child was given plenty of food, and at first she seemed to improve a little, but this improvement soon passed away, and by the second week in April it was clear that the child was weaker and more pale than on admission. To begin with, the spleen diminished a little, but not more than half an inch in its vertical measurement, and this diminution soon stopped. On admission the temperature ranged between 99° and 100° for a week; it was then normal for a fortnight, then raised to between 100° and 101° for a week, and for the rest of the child's life it was normal. The following blood counts were made:—

9th March.—Red cells, 3,950,000; white cells, 3,700; hæmoglobin, 60 per cent.; colour index, 0·683. Differential white count normal.

12th March.—Red cells, 4,060,000; white cells, 2,187; hæmoglobin, 50 per cent.; colour index, 0·55. Differential white count normal.

19th March.—Red cells, 4,675,000; white cells, 1,600; hæmoglobin, 55 per cent.; colour index, 0.53. Differential white count normal.

26th March.—Red cells, 4,425,000; white cells, 1,875; hæmoglobin, 55 per cent.; colour index, 0·53 per cent. Differential white count normal.

3rd April.—Red cells, 3,100,000; white cells, 3,150; hæmoglobin, 65 per cent. Differential white count normal.

11th April.—Red cells, 5,200,000; white cells, 3,125; hæmoglobin, 60 per cent. Differential white count normal.

Her weights were as follows:—22nd February, 4 st. 1 lb. 12 oz.; 26th February, 4 st. 1 lb. 6 oz.; 5th March, 4 st. 2 lb. 8 oz.; 12th March, 4 st. 4 lb. 0 oz.; 19th March, 4 st. 1 lb. 8 oz.; 26th March, 4 st. 0 lb. 12 oz.; 2nd April, 4 st. 1 lb. 4 oz.; 9th April, 4 st. 0 lb. 8 oz.

When the diagnosis was first made, it was explained to the parents that it might be desirable to remove the spleen. They said they were quite willing for the operation whenever we thought it necessary. We watched the child for six weeks to see if there was any improvement, but as at the end of that time she was weaker and paler, she had lost weight, the spleen was not diminishing in size, and there was no real improvement in the state of the blood for the hæmoglobin was only 50 per cent., and the white cells were certainly showing no tendency to return to their normal number, it was, after consultation with Mr. Fagge, decided to remove the spleen. This was done on April 11th. The operation proved to be one of great difficulty, for the spleen was firmly adherent to the under surface of the diaphragm and the left kidney, and when these adhesions were at last broken down there was much oozing of blood from them. The patient was, on her return to bed, very collapsed, and died a few hours after the operation. At the post-mortem examination 25 ozs. of blood-clot were found in the upper left part of the abdomen, this blood evidently came from the vessels in the torn adhesions, and it was clear that this hæmorrhage was the cause of death. The spleen was firm, there was much perisplenitis, and it weighed 27 ozs. There were minute grey tubercles in the bronchial glands, liver, and spleen.

Case 2.—A man, aged 63, who looked pale and yellow with a tint not unlike that of pernicious anæmia, first came to see me on the 3rd April, 1913. He gave a history of having had two severe attacks of vomiting of blood, the first about two years ago. This pulled him down very considerably and he regained strength very slowly. He had a second severe hæmorrhage with much melæna and some vomiting of blood on the 5th of December, 1912. This

made him seriously ill, but he gradually gained some strength. He now complains of great weakness and inability really to do anything properly. From being a man who could take active exercise, he is now one who can hardly walk, and feels he cannot get up till 11 in the day.

On examining him the spleen was found to be uniformly enlarged, reaching almost down to the umbilicus. The liver appeared normal in size; there were no enlarged glands anywhere in the body, nor, in fact, by ordinary physical examination could anything be made out wrong excepting the enlargement of the spleen. The heart, lungs, and urine were all perfectly normal. His blood examination on the 28th March, 1913, showed red cells, 4,000,000; white cells, 4,375; hæmoglobin, 65 per cent. There was nothing abnormal in the differential count of the white cells.

Another blood examination on the 4th April, 1913, showed red cells, 4,250,000; white cells, 4,500; hæmoglobin, 57 per cent; colour index, 0·68. The differential count of the white cells was normal. There was nothing wrong to be seen with the red cells, and no myelocytes were seen.

The diagnosis of splenic anæmia was made, and the patient was advised to have the spleen taken out. This diagnosis and opinion were confirmed by Dr. Frederick Taylor, to whom the patient was sent for a further opinion, and by Dr. Wardropp and Dr. Macnaughton, both of whom saw the patient.

The spleen was excised on April 22nd by Sir Alfred Fripp. There were a few slight adhesions. These were successfully dealt with, and the patient did well after the operation; he left the nursing home and went into the country. I have since heard that he died there. Unfortunately there was no post-mortem examination so I do not know the cause of death. I show you the spleen. You see it is uniformly enlarged. It weighs 21 oz. There is some thickening of the capsule (perisplenitis).

The reasons for advising the excision of the spleen in these cases were (*a*) as far as is known no other treatment benefits the disease; although the patients will in the natural course of the disease probably live a long while, yet they are in a continued state of weakness and illhealth, so as to be unfit for the ordinary duties of life. Our second patient said he would sooner die than go on as he was. He could not get up before 11 a.m., and could not walk half a mile. (*b*) If sufferers from it have hæmatemesis, as our second patient did, there is always the risk of death from this.

In each of these two patients, the problem was to determine the cause of the enlarged spleen.

The spleen is often enlarged in fevers, especially typhoid fever, but our patients obviously had not that, nor had they myeloid leuchæmia, there were no myelocytes in the blood; nor lymphadenoma, for they had no enlarged glands anywhere. Malignant endocarditis is a frequent cause of an enlarged spleen, but they had not that, nor heart disease in which the spleen is often somewhat enlarged. The spleen, too, may be enlarged in malaria, they gave no history of that; nor was there any evidence of syphilis or lardaceous disease. Tuberculosis is often associated with an enlarged spleen, but there was no evidence of this. It may be a little enlarged in malignant disease, but patient had neither this nor pernicious anæmia in which the spleen is rarely enlarged, nor was there anything to show that either had cirrhosis of the liver which may be difficult to diagnose from the late stage of splenic anæmia in the absence of a history that the enlargement of the spleen was observed before the hepatic cirrhosis, for in this disease enlargement of the spleen and hæmatemesis are common. We had nothing to indicate that either patient had malignant disease, abscess, or cyst of the spleen. Thrombosis of the splenic vein may cause an enlarged spleen, but this is very rare and the diagnosis usually impossible, so we were driven to decide that our patients had splenic anæmia, an opinion confirmed by the examination of the blood.

Splenic anæmia may be defined as a chronic disease with considerable enlargement of the spleen that is correlated with no known cause. There is secondary anæmia with leucopænia. There is a tendency to hæmorrhage, especially gastric, and in many cases a terminal stage of cirrhosis of the liver.

It was originally described by Banti, who, however, only recorded the terminal stage of some cases, and, therefore, the disease was known for a time as Banti's cirrhosis. It is to Sir William Osler that we owe most of our knowledge of splenic anæmia, and he showed that Banti's cirrhosis was only the terminal stage of splenic anæmia.

The cause of the disease is unknown. All bacteriological investigations have been negative. It is, however, probably primarily a disease of the spleen, for:—

a. The enlargement of the spleen is the first symptom.

b. Many patients are much better when the spleen has been taken out.

c. The final stage of cirrhosis of the liver looks as though poisons were constantly being conveyed, in this disease, from the spleen to the liver.

It is more frequent in males than females, and is most commonly seen in middle-aged people. The chief symptoms are the uniform enlargement of the spleen which often weighs over 60 ozs.

The anæmia. There is a diminution, but not great, of red cells. A considerable diminution of hæmoglobin. A great diminution of the white cells. The differential count of white cells is normal, and there is nothing abnormal in the reds. In 40 or 50 per cent. of cases the patient, sometime or another, vomits blood, perhaps usually in the latter half of the illness, but the vomiting of blood is not necessarily related to the cirrhosis. Occasionally there may be hæmorrhage elsewhere.

It is important to remember that the disease is chronic, and may go on for several years, but the patients having it are generally weak and far below the average health, so that they are unable to do the ordinary duties of life. The man whose case I have related to you was very weak and feeble, and could not get up till eleven in the day, and could only walk about half-a-mile. Rarely there is some brown pigmentation of the skin. If, at the end of the disease the cirrhosis is striking, there may be some ascites, and a little jaundice, and if the anæmia is severe there may be a little œdema of the ankles. Occasionally these patients have slight rise of temperature.

At the post-mortem the spleen is uniformly enlarged, and generally, as in the second patient, whose spleen is seen before you, the capsule is thickened.

I can best describe the histological appearances of the spleen by reading to you the histological report of the spleen in the second case:—

"The section of this spleen shows considerable increase of the fibrous tissue elements. This change chiefly affects the splenic pulp where the reticular connective tissue is increased to such an extent that the histological structure of the pulp is almost obscured. The Malpighian bodies show some increase of fibrous tissue in their periphery, and in a few instances the adenoid tissues appear broken up by it. Of the cellular elements the red blood cells are few in number and the amount of lymphocytes appears less than normal, while the endothelial elements are prominent. No abnormal cellular elements are present. The changes found in the section of this spleen are those associated with a condition of splenic anæmia."

This is an admirable description of the usual state of the spleen in this disease, and may be summed up by saying that in this disease the spleen undergoes a general fibrosis.

There is a rare disease described by Gaucher in which the endothelial cells are very much increased, but these cases are very rare and their exact relationship to splenic anæmia has not yet been decided.

The terminal cirrhosis of the liver is exactly like that seen in patients who have taken too much alcohol. The veins leading from the spleen to the liver may be a little thickened or even atheromatous, and the bone marrow shows secondary changes such as you see in severe forms of anæmia.

The outlook of these cases is bad, in that the patient remains weak and unable to do his work, and gradually gets weaker and weaker.

With regard to treatment, no drug that has been tried has done any good. X-rays over the spleen have also been used. We applied them in our first case but no benefit resulted. As far as is known, the only thing that can do these patients any good is to remove the spleen. It is, unfortunately, a severe operation with a mortality of between 25 and 30 per cent. Our first case indicates the chief danger of the operation, viz.: dense adhesions, the separation of which in taking out the spleen leads to considerable hæmorrhage. You will remember that this was the cause of death in our patient, but if these patients survive the operation of taking out the spleen they appear to regain strength and do well. How long they live cannot yet be decided, for the operation is comparatively recent, but many cases have lived for several years in excellent health and are still alive.

Some of you may think we have not laid much stress upon tubercles found at the post-mortem of the first case, but I do not think that our finding them ought to make us alter our diagnosis of splenic anæmia. Still it was suggested that as patients with tubercle may have an enlarged spleen, ought we not to regard our first case as an example of tuberculosis. My reasons against that view are that the tubercles found at the post-mortem were very early and few in number, indeed, so early and few, that they can hardly have been the cause of the patient's illness; there was very little rise of temperature, certainly not enough on which to

found a diagnosis of miliary tuberculosis, and lastly, all the blood counts were exactly those that we should have expected in the case of splenic anæmia.

Under the microscopes you will see sections showing the fibrosis of the spleen in each of our cases.

German Hospitals and Research in Medicine.

BY E. P. POULTON.

THE general arrangements of a German and English hospital would probably appear very much the same to a casual visitor. However, for anyone who has worked for several years in an English hospital, small differences in hospital management and nursing attract the attention. Some of these differences are due to national customs. I do not suppose there are many living rooms in Germany without the tall porcelain stove in the corner, and the doubly barricaded window to keep in the warmth, a window which would be opened in summer, but tightly sealed practically the whole winter.

In the wards of a hospital the stoves are, of course, replaced by central heating, but the double windows are there just the same, and the atmosphere is the more overpowering as the wards are less airy and more crowded than ours. In some hospitals, *e.g.*, in Munich and in the recently equipped first medical clinic in Vienna, the wards are rather small, containing at most 20 beds and often only five or six. From a nursing point of view they are managed as if they were a succession of private rooms in a nursing home, a nurse looking in occasionally to see that nothing is going wrong.

Perhaps the most noticeable difference is the lack of formality in Germany between patients, nurses, and doctors, except, perhaps, when the Professor himself is making his round. There may be a small table in the ward, used ostensibly by the clinical clerk, or the co-assistant, for writing the reports. This table will be used by a patient who has a letter to write, and he just moves on one side and continues writing when the clerk arrives.

During the daily round of the assistant, a man who may occupy a similar position to that of assistant physician with us, one of the nurses may interpose a remark on her own initiative, and the assistant's further speech may be interrupted entirely by a discussion between two of the nurses and a clerk as to something that may or may not have occurred.

There are several things which may account for this informality. There is no regular medical teaching in the wards as with us, and the clinical clerk, who has usually just become qualified, is on quite familiar terms with the assistant who is doing the round. One of the most important functions of a big hospital in London is that of a training school for nurses, which implies a stricter dicipline than would occur with nurses who have been working in the same institution for years.

Germany is the land of spas, and so much importance is attached to this kind of treatment that a Bathing Establishment is considered a necessary part of every hospital and also of every out-patient department. This treatment, which can only be obtained in England by those who can pay handsomely, is in in Germany readily obtained by the poorest classes. At the first medical clinic in Vienna there is actually a course for students on the art of giving baths.

In a large new hospital recently built at Schwabing, a suburb of Munich, the Central Bathing Establishment is magnificent. On each side of a wide lofty corridor small rooms lead out containing hot-air baths, steam baths, sand baths, mud baths, electric light baths, galvanic baths, and carbonic acid baths. At the end of the corridor there is a magnificently tiled hall containing a swimming bath with water sprays springing from every direction, from the floor and wall and also from the ceiling. In the same hall there is a long narrow bath containing water about 3 feet deep, with a coloured line running along the bottom. The object of this bath is to teach tabetics to walk. They have to walk along the line up to the waist in water, and any violent inco-ordinated limb movements are supposed to be arrested by the viscosity of the water.

A gymnasium is also attached to the baths, and this usually contains a room with an assortment of machines for exercising all parts of the body from the hip-joint to the finger-joints. A special type of machine produces vibratory massage over the back, which can be used in lumbago, and another machine causes passive movements of the limbs and is used in exercising cases of heart disease.

Radium cures have been recently introduced in many places for use in medical cases, not only at the fashionable spas, but also in various hospitals. This treatment is tried for the general run of intractable medical cases, such as chronic joint diseases, sciatica, lumbago, lightening pains, etc. The radium can be administered in four different ways: water containing the radium emanations in solution is drunk; patients may be given sittings in an emanatorium, where the air supplied is charged with the radium emanations; dilute solutions of radium salts are sometimes injected beneath the skin in the neighbourhood of affected joints; or radium compresses may be applied externally.

Vienna is the centre of the radium industry, and the hospital gets a daily supply of the emanation free of charge. There is a Radium Out-Patient Clinic held

twice a week, and much stronger doses of the emanation are employed than at other places. In fact, at some of the spas, though the treatment is much advertised, the atmosphere breathed contains only a small amount of the emanation. One cannot help being rather sceptical about the actual results of the treatment. They appear striking enough when published, as improvement occurs in a high percentage of cases; however, in interpreting these results there are various things to be considered. The joint cases are mostly of that chronic type with well-marked bony changes that come up at intervals to our O.-P.'s, now a bit better and now a bit worse. A course of radium treatment takes several months, as the radio-active water is first administered, and then if no improvement occurs the patient has sittings in the emanatorium, first of all weak and then strong doses being employed, and finally subcutaneous injection is adopted. Whatever the treatment, there is every probability that some change in the joint condition would occur in the course of several months. As the condition of the joint would be bad when the treatment was started, the probability is that the change would be of the nature of an improvement. Such a fallacy leading to a wrong interpretation of the efficacy of the treatment could be eliminated by a careful series of controls, but controls have not been carried out. In the policlinic at Munich where an apparatus for giving radio-active waters by the mouth was installed at considerable expense, the results were not encouraging, and the treatment has been abandoned.

One notable difference between Germany and England as regards hospital control is, that in Germany all hospitals are provided by the municipality or the state. There is no sharp distinction, as in England, between the voluntarily supported hospital and the municipal infirmary, because the voluntary system does not exist. Another difference is that the Insurance Act in Germany has, within recent years, caused a large increase in the hospital accommodation. The insured persons have insisted on hospital treatment rather than treatment in their own homes. Certainly no expense has been spared in the fitting up of the hospitals. In Berlin the Rudolph Vircluns hospital of 3,000 beds was built. In Munich the huge new hospital on the outskirts of the town, at Schwabing, has been built on a most princely scale and cost about £850,000.

In Germany the hospitals are meant for, and are used by, all classes of the community, and they thus act the part of the nursing home in England. There are three classes of patients: the first-class patients are given a separate room, and are obliged to pay; the second-class patients pay less, and usually the beds are in wards; the third-class patients pay nothing at all, and these are the patients that are demonstrated on in the clinics. An insured person has a perfect right to refuse to be shown in the clinic, and very occasionally this right is exercised. Usually they do not mind, and sometimes a patient from the second-class allows himself to be shown. No ill-treatment of patients by over-anxious students occurs in the clinics. Stories of this kind must relate to occurrences many years ago.

The amount of clinical material available from a teaching point of view of course varies in different places.

The medical hospital in Leipsic has 800 beds; the amount of clinical material is so great as to be almost bewildering. The importance of Leipsic as a centre for trade between east and west ensures the presence of a number of unusual cases, especially about the time of the Leipsic Fairs, and there is a special pavilion in the hospital grounds for small-pox, cholera, etc. There is no rule about the complete isolation of small-pox in a special hospital.

In Munich the conditions are less favourable, as most of the patients are insured persons, and the hospital authorities are obliged to provide a bed for any insured person who claims admission. It is only after the patient has been examined in the ward that the doctor can discharge him if there is nothing the matter. However, interesting cases are often sent specially to the clinic from other hospitals in the town.

In Heidelberg the hospital authorities have the power of selecting their patients, as in a London hospital, and so the cases in the wards are of much greater interest.

In a University town the chief physician in the hospital is also the University Professor. The appointment is thus twofold in nature, and is made partly by the state or municipality, as the case may be, and partly by the university. In view of the fact that the entire medical teaching of the university is in the hands of one or two persons, the greatest care is needed in their selection. Incapacity in the teachers would be fatal to the university. When a chair becomes vacant the electors offer the position to any man in any other place they think the best, whether he is already a professor or whether he holds a subordinate position. The election is treated quite publicly, and sometimes a list of first, second, and third choice for a post is published in the newspapers. In many cases a man prefers to remain where he is, and he sometimes receives a rise in salary as a compensation.

The selection of a man for an important chair often entails a system of general post, as his chair has to be filled, and this creates another vacancy, and so on. A man is practically never offered the chair of medicine in the university in which he is working at the time. The highest position he could occupy there would be that of assistant professor. The system of the selection of professors from other universities

extends throughout Germany and Austria, and there is a fairly free interchange of professors between the two nations. It occasionally happens that Germans are offered, and accept, chairs in the United States, though the converse never occurs.

By this method of selection the chairs of medicine in an important university will be filled by men who have already proved their capacity in teaching and research. However, this constant migration of teachers from one university to another, to a certain extent, fails to produce that spirit which is prized in many English institutions. Tradition, a special characteristic of an Oxford and Cambridge college, for example, is due in great measure to the permanence of the teaching staff, to the fact that the majority of the fellows, and often the head of the college, have spent the best part of their lives in the service of the college, and the same thing applies to a London hospital medical school.

However, in Germany a student's life is quite different from what it is in England. Tradition, or esprit de corps, hardly exists at all. Besides the constant migration of teachers throughout the land, the students themselves are constantly wandering about, and resemble in this way the students of mediæval times. A man may begin his preliminary studies at Marburg, he may, perhaps, go to Munich for a winter session, partly because he wants to hear Prof. Müller, but also because of the ski-ing in the Bavarian Highlands, and last, but not least, the Munich beer, and the carnival time just before Lent. He may finish off in Freiburg, and there take his qualifying exam.

Other factors tending in the same direction are the absence of games, the fact that all students live in lodgings, and the very high percentage of foreigners, particularly Russians, and perhaps also, the presence of women students on the same equality as men. In Leipsic the medical school is small, and Russians abound. In Munich the medical school is very large, even larger than in Berlin, but owing to the lack of accommodation the authorities have been obliged to decree that not more than a certain proportion of foreigners shall be admitted. The German students often complain very bitterly of the pushing nature of these foreigners, especially of the Japanese.

The lack of esprit de corps in the medical school is no doubt made up for by the existence of the various student corps. On the other hand, it must be remembered that when a man is an active member of a fighting corps he has very little time for anything else, and so can hardly be looked on as a medical student until he has ceased to be active. His first year especially is fully mapped out: every morning he has to spend a long time in practising fencing, with intervals for beer and refreshments; and every evening he has to attend the kneipe, with its formal meeting of the whole corps, which lasts until the small hours of the morning.

The routine medical work of a hospital, though superintended by the professor, is actually carried out by a number of assistants, "assistenten."

The assistant corresponds, in certain ways, to the house-physician in England, but, in other ways, he has the powers of an assistant physician. He is chosen out from among the best students of the year, and remains an assistant, until he receives a call to another university, or sets up in practice on his own account. The actual responsibility delegated by the professor to his assistants varies in different places. In Munich, where the number of students is very large, the assistants are given a free hand. The professor rarely makes a fixed round, as most of his time is taken up with teaching and examining. In Heidelberg, however, where the work is lighter, Professor Krehl goes thoroughly round half the hospital each morning, and does not take a holiday even on Sundays, as he says that if he did so, some of the assistants might be tempted to take the day off as well.

The assistant is usually unmarried, and is resident in the hospital, and is liable to be called up at night. There are certain disadvantages in having an assistant who is married. He does not reside in the hospital, and it is found that he becomes nervous of carrying home infectious diseases to his wife and family, for in Germany the infectious diseases are treated in a general hospital, though confined to a special block.

In a big clinic the post of senior assistant is a very important one. It may be held by a man over 40 years old, who may have gained a European reputation. He will probably have obtained the title of assistant professor in the university. Others of the assistants may have obtained the university title of "privat-dozent." The assistant, especially if he is under an exacting professor, has a pretty hard time of it. The investigation and treatment of patients are in many ways more difficult for him than for an English H.-P. There is no bacteriological department, with its trained staff of investigators to whom specimens can be sent for examination, or by whom autogenous vaccines can be prepared. There is no specially trained chemist in a laboratory of his own to perform out-of-the-way tests, such as discovering the presence of arsenic in hair. Investigations of every kind must be undertaken by the assistants themselves, and on this account the results are probably not so satisfactory as with us, and on several occasions I have heard the question discussed of a septicæmia being caused by the ubiquitous staphylococcus albus. The usual plan is for the assistants to specialise in particular branches, such as bacteriology, nervous diseases, etc., and some saving of time is effected in this way.

During the session the senior assistants always take an important part in the teaching. All the special courses to students in clinical methods are given by them, and they may have to do post graduate teaching as well. In addition to all these various duties, the

assistant must find time for research, as it is only by this means that he will become known in the outside world, and on this depends his chance of becoming the head of a clinic of his own.

The life of an assistant may not be so wearing as that of an H.-P. with us; for, though he may spend more time at his work, it is more evenly distributed, and he has no take-in week to upset his routine. On the other hand, it must be remembered that he resides for years continuously in the hospital, and all his spare time is spent in the hospital or its laboratory, and he has only one month's holiday in the year. An H.-P. is sometimes knocked up by the end of his six months. It is no wonder that the assistant in a German clinic sometimes breaks down in health in the course of years.

The summit of ambition of an assistant is to become the head of a clinic, but the number of these posts is very limited, and so the competition is keen. These posts are regarded as the greatest prizes in the profession.

In this connection it is interesting to compare Germany and England. In England the view is often expressed that if an attempt were made to get professors of medicine to teach most of the clinical work in London, the best men would not apply for the posts because they would prefer the greater freedom and interest of a consulting practice to the dignity of an academic position.

In Germany the academic status has at present a much greater social importance than with us. This is well illustrated by the fact that it is a mark of special politeness for a tradesman to call a young man Herr Doctor. When the international Zoological Congress met in Berlin it was accommodated in the buildings of the Reichstag. Imagine the president of any international congress occupying the Speaker's chair in the House of Commons!

Berlin society has recently approximated in character to London society, but Berlin does not hold such a prominent place as London among other towns. The medical school in Berlin is very important, but there are other universities in Germany, with medical schools just as important, and the professors have sometimes refused to move to Berlin on receiving a call to the chair of medicine there.

Munich, though the capital of Bavaria, is of second rate importance as a town, and is admittedly a bit behind the times; but the university is of first-rate importance. Society in Munich has not changed its character like Berlin Society. The society of the court keeps itself quite distinct from the middle classes. A German who is not blessed with at least the prefix "von" to his surname will never be received into this society, however successful in business he may have been. University teachers become the natural leaders of a large middle-class society, which is absolutely cut off from the aristocracy. The most celebrated of the professors will have been given the title "Geheimrath" (Privy Councillor) by the Sovereign, and they and their wives will be received into court circles, but their children will still be excluded. In other university towns the social position of the university professor is just as high as in Munich.

In addition to the social importance of his position, the professor of medicine is looked upon as the undisputed head of his profession in the town and neighbourhood. During the winter session Professor Müller gives a clinical lecture on one evening in the week to the doctors of the town, usually taking subjects he has already talked about in the clinic. Doctors of all ages simply flock to hear him, completely filling the largest lecture theatre in the hospital. When the Prince-Regent is ill the university professor is called in, in consultation. When the mental condition of the King of Bavaria is examined it is Kraepelin, the professor of psychiatry in Munich, who is called in to do it. It would be highly exceptional for a specialist from Berlin to be sent for in the first instance. The Bavarians are proud to believe that their professors are as eminent in their profession as any in Europe, and other towns will have the same belief in their own men.

A professor's private practice is limited in amount, but yet it is considerable. A conscientious man will spend his mornings at the clinic, and will have a few evening and afternoon lectures to deliver as well. All the rest of his time will go to his practice. He will start seeing patients at two o'clock, and will continue seeing them till late at night, and a certain class of private patient will be seen in the clinic during the morning. It is perfectly obvious that the man who will impress medical students, as a lecturer, will be a man with a private practice of his own, and this is just as much realised in Germany as in England. There is an unwritten rule as to how much time a man should give up to his hospital work and how much to his private work, and this rule is very generally obeyed. There is one notorious exception: The professor leaves the hospital half an hour after his clinical lecture is finished, and spends all the rest of the day in private practice.

The income of a university professor in Germany will rarely amount to as much as a London consultant, but this does not detract from the value of the position, because in Germany all medical fees are low, and the general standard of living in the social class to which the professor belongs is lower than it is in England. He will, any how, be a good deal better off than the majority of his friends.

There are thus a very great many inducements to lead a man to the professional life. The question arises as to how this position can be obtained. There is only one way, and that is by research. The as-

sistant must, of course, reach the necessary standard in his clinical work, but the greatest clinical acumen will not be of any use to him if he does not research as well, and consequently he does so.

The atmosphere of research in a German hospital is further assisted by one special circumstance. Every student must do at least one piece of research in his life, in order to take his doctor's degree. Very poor stuff some of these theses are to be sure; they may be undertaken by men very little qualified in laboratory methods, and may be finished before the man has passed his qualifying examination, but the fact that they have to be done helps the feeling in the clinic that research is the thing to do. In England the M.D. degree is often given on an examination alone; all the higher qualifications, except one, are given purely as the result of an examination in which the element of luck plays some part, though other factors may come in in some cases. In Germany these higher examinations simply do not exist; after a man is qualified his career will depend almost entirely on his published work and his power of teaching intelligibly.

Though there are great advantages about such a system, there are also certain disadvantages. A man is tempted to believe that anything is good enough to publish. He may get his clerks to investigate his ward cases. These men may be quite unqualified for the task, and there will not be much tendency to check the results with care, and they may be disproved later, perhaps; but that will not so much matter if the author has already started on his upward career. It is the first step that is the difficulty. The enormous number of periodicals in Germany, not only in the pure sciences of physiology, pathology, and pharmacology, but in every branch of medicine as well, testify to the amount of work that is being done. At the same time it is often very difficult to pick out the trustworthy from the untrustworthy. In the smaller amount of work published in England it is usual to look upon every paper as at least a genuine attempt to get at the truth.

The professor of medicine is regarded as the director of research in his clinic. It is to his interest to see that only work of the very best comes from his laboratory, but his many other occupations prevent him from knowing thoroughly what is taking place. For one thing, he obviously cannot keep up with the literature, and many of the laboratory methods have been completely altered from the time when he was a student, and he has never had time to familiarise himself with them. It is impossible, therefore, that he should really be able to direct research except in the one particular line he has made his own. In a large clinic research will be carried out along a dozen different lines, and one can imagine cases in which the professor's ignorance of the subject may seriously handicap a young man who wishes to work out ideas of his own. At the same time it is only fair to say that most men realise their deficiences, and direct research in name only.

The German professor very much appreciates his complete autocracy in the hospital, lecture room, and laboratory, and he no less emphatically condemns the position of the clinical teacher in England. But this one man show is really the weak spot in the German system, and we have just seen how it breaks down in the matter of directing research. The professor of a purely scientific subject in England, or Germany, or anywhere else, has only his teaching and research to think about. It pays to give him absolute power in his own department; at any rate he has the time to find out what is going on there.

The German professor of medicine, who has, perhaps, as large a laboratory under his direction as many purely scientific professors, has twice as much on his hands, as he has also to look after his hospital and his private practice. He thus spends his life in trying to do conscientiously just twice as much as any other professor in the world—an impossible state of affairs.

The strong point in the German system, when looked at in regard to the advance of medical science, is the atmosphere of research that exists not only in the clinic, but throughout the profession and in all parts of the community. It is this feature that might be imitated in England, but it would be a mistake to introduce into London medical education all the weak points of the German system in addition.

A Form of Glycosuria first observed by the late Dr. Pavy.

BY E. L. KENNAWAY.

IN the memoir of Dr. Pavy, published by Dr. Frederick Taylor in the last volume of the Guy's Hospital Reports, one reads that Pavy found glycosuria to be produced by removal of the superior cervical ganglion.

In a recent number of the Johns Hopkins Hospital Bulletin, Harvey Cushing and his fellow-workers (1) describe experiments which showed that electrical excitation, or even mere exposure by dissection, of this ganglion produced glycosuria unless the posterior lobe of the pituitary had previously been excised.

It appeared to be of some interest to ascertain whether Pavy and the later workers had both been dealing with the same phenomenon, and Dr. Frederick Taylor was kind enough to supply the exact references to Pavy's papers on this subject, which appeared in 1859.(2)

The American workers stimulated the superior cervical ganglion electrically in 40 experiments on dogs, cats,

and rabbits, obtaining in all cases a marked glycosuria, which appears within 15 minutes of the stimulation. Mere manipulation of the ganglion in the course of a free exposure has the same result. The effect of the anæsthetic was controlled by numerous other operative experiments which did not produce glycosuria. The chemical tests employed were the reduction of Fehling's and Nylander's reagents, and the observance of dextro-rotation. An essential condition for the production of this glycosuria is that the animals must have a store of what Cushing calls "available glycogen," which term is the subject of a very interesting discussion in an appendix to his paper. The previous diet must have been abundant; in the case of dogs, exercise must have been restricted by confinement for at least three days; and a sufficient interval must have elapsed since any previous operation causing a discharge of glycogen (*e.g.*, Bernard's puncture, stimulation of hepatic nerves, direct stimulation of the pituitary, etc.).

Stimulation is still effectual after division of both the cervical sympathetic and vagus nerves, and after administration of nicotine. Any action upon the liver or suprarenals through the splanchnic nerves was excluded by experiments in which glycosuria was found to be produced after transection of the spinal cord at the fourth dorsal segment. The work was then directed so as to ascertain whether the pituitary was concerned in the production of this glycosuria. The ascending branch of the superior cervical ganglion in the carotid canal gives off nerves to the pituitary which are readily seen in a dissection of the cavernous sinus. Four dogs were employed in which the posterior lobe of the pituitary had been excised some weeks previously. They were especially well fed, and were given cane sugar by the stomach tube to ensure the presence of abundant glycogen. The superior cervical ganglion was exposed and stimulated electrically, and in no case did glycosuria occur. After any such negative result, Cushing demonstrates the presence of "available glycogen" by some other independent method, such as stimulation of the hepatic nerves; but an injection of posterior lobe extract, which had been shown in a previous investigation (3) to produce glycosuria, would have formed the most conclusive termination to this experiment. Further observations showed that direct electrical stimulation of the pituitary was followed immediately by glycosuria, no such result being produced by the operation of exposure alone. Cushing concludes that the action of the pituitary upon carbohydrate metabolism is controlled by impulses conveyed by the post-ganglionic fibres in the ascending branch of the superior cervical ganglion.

Pavy, in his paper on "Lesions of the Nervous System producing Diabetes," brings forward the results of a long series of experiments, of which thirty-nine are described in detail. The animals employed were dogs and rabbits; many of the operations were performed under chloroform; in others, the nature of the anæsthetic is not stated. The chemical test used was the reduction of Barreswil's solution.* He found glycosuria to be produced by strychnine poisoning, asphyxia, decapitation, destruction of the medulla, division of the branches from the stellate ganglion to the vertebral canal, and by excision of the superior cervical ganglion. Of this last method he says, "Of all the operations I am acquainted with, the removal of this ganglion is the most certain and speedy in producing diabetes in the dog." An experiment is described in which one superior cervical ganglion was removed in a dog; glycosuria appeared within an hour, and lasted twenty-four hours. After a day's interval the opposite ganglion was removed, and glycosuria again appeared, its duration not being recorded. The importance of "available glycogen" appears to be shown by an experiment upon a badly-nourished dog which had a defective gastric fistula. The removal of one ganglion produced no glycosuria; after removal of the other the urine gave an inconclusive appearance of reduction. Removal of the ganglion in rabbits was also followed by glycosuria, but its onset was not so prompt as in the dog.

No very detailed comparison of the experiments of Pavy and of Cushing can be made, since Pavy did not use electrical stimulation, and Cushing performed no simple excisions. However, Pavy describes one experiment on a dog in which "the ganglion on each side was exposed, and all its descending branches torn through," without actual excision; the urine subsequently "gave the strongest reaction for sugar." This operation corresponds closely to one of many performed by Cushing, also on dogs, in which "the superior cervical ganglion was freely exposed," and the urine afterwards "gave marked reduction of Fehling's solution." When one reads Cushing's description of the ease with which mere manipulation of the ganglion produces glycosuria, one can have little doubt that the same result was produced in Pavy's experiments in which the ganglion was "torn away from its connections and altogether excised," and hence one must conclude that Pavy was the discoverer of this form of glycosuria.

No doubt Pavy never thought that the pituitary was concerned in the matter. He supposed "the medulla oblongata to form a centre, giving to the liver a force preventing the saccharine metamorphosis of its hepatine,"† and apparently had in mind that the cervical sympathetic might convey descending impulses from the medulla to the liver. At that time, before the

* A solution differing from Fehling's only in containing potassium hydrate and tartrate.

† No doubt Pavy was unwilling to adopt the word "glycogen" because it implies that the substance is a source of glucose.

work of Gaskell and of Langley and Anderson, the data available as to the nature and connections of the sympathetic system must have been extremely vague. Moreover, the pituitary was then neglected and mysterious, and did not hold, as it does now, the position of a fashionable and potent organ.

Pavy performed many other operations (division of the mid-brain, division of both vagi, ligature of the carotid and vertebral arteries) which were not followed by glycosuria. A noteworthy difference between his results and those of Cushing lies in the fact that Pavy obtained no glycosuria after division of the spinal cord in the cervical region, whereas Cushing found an immediate glycosuria after transection at the fourth dorsal segment; possibly the close proximity of the latter lesion to the origin of the splanchnic nerves may account for the difference.

Cushing's paper raises an interesting question as to the output of pre-ganglionic fibres from the central nervous system. Since any stimulus applied to the superior cervical ganglion produces glycosuria, one would naturally suppose that excitation of the pre-ganglionic fibres in the cervical sympathetic would have the same effect. Cushing, however, in spite of numerous attempts, was never able to produce glycosuria by stimulation of this nerve, although stimuli applied to the ganglion in the same animals were effectual. To explain this, he prefers the suggestion that the fibres concerned degenerate instantly upon section and stimulation, which seems very improbable, but he remarks that the ganglion may receive pre-ganglionic fibres from some other source. The ganglion, of course, gives grey rami to the upper three or four cervical spinal nerves, and might quite possibly receive some pre-ganglionic fibres from the cord by this route. Langley was unable to obtain sympathetic effects from any spinal roots except those of the thoracic and lumbar regions, but if the supposed fibres in question were concerned only with the supply of the pituitary, their effects would not be detected unless they were specially looked for. Unless there is some such connection with the central nervous system, it is difficult to see how the action of the ganglion upon the pituitary can be regulated in accordance with the needs of the body as a whole.

In an earlier paper from Cushing's laboratory (3) an elaborate investigation of the effect of the pituitary upon carbohydrate tolerance in dogs is reported. Injections of extract of posterior lobe (pars nervosa and intermedia) lower tolerance, and in sufficient amount produce glycosuria; repeated injections lead to emaciation. Removal of the posterior lobe increases tolerance by from 10 to 100 per cent., and it may be difficult to exceed the limit without producing vomiting; the tolerance can be reduced to the normal level again by an appropriate dose of posterior lobe extract. A comparison of the histological and chemical results appeared to show that the degree of tolerance attained was dependent upon the completeness with which the pars intermedia had been removed. Dogs deprived of the posterior lobe become fat and lethargic, have a subnormal temperature and show extreme atrophy of the generative organs, but their life does not appear to be shortened. The emaciation and adiposity produced in these ways are well shown in the photographs of dogs in Cushing's book, "The Pituitary Body and its Disorders." Removal of the whole anterior lobe was found to be fatal within a month; in a case of partial removal of this lobe without any pars intermedia the tolerance was not affected. Extracts of the anterior lobe are about half as active as those of the posterior lobe in lowering tolerance; their effect may be due to admixture with pars intermedia. These results have been confirmed by Aschner (4).

Cushing's book contains details of numerous cases of pituitary disorder in which the carbohydrate tolerance was raised, and of one case (an early acromegaly) in which it was lowered. One of the patients could retain 450 grams of levulose, about 100 grams being the normal limit. Some similar cases were shown at the discussion on the pituitary at the Royal Society of Medicine last March; Dr. Batten's patient, a very fat boy of 16, showed no glycosuria after taking 300 grams of dextrose, whereas 150-200 grams is the limit in a normal adult. Conditions of altered tolerance in association with pituitary disorders are of course of interest in comparison with the lowered tolerance seen in Graves's disease and in animals after parathyroidectomy (5), and the increased tolerance in myxœdema and in Addison's disease (5).

Cushing does not say whether excitation of the superior cervical ganglion produces any other signs of discharge of pituitary secretion (pressor and diuretic effects, secretion of milk) besides the glycosuria. Possibly the glycosuric effect is due to a distinct substance, which is, under these circumstances, discharged alone; the galactogogue effect appears to be due to a substance which has no action upon the blood vessels or kidney (6). The pituitary seems not to be responsible even in part for the emotional glycosuria of the cat, since this is completely absent after adrenalectomy (7).

To return in conclusion to Pavy's paper, one may note an instance of his care in considering all the possibilities of a subject. He says in one place, "Regarding the medulla under this light—regarding it as a centre, either directly presiding over the functional activity of the liver, or indirectly affecting it, by altering, through the medium of another or other organs, the condition of the blood going to it," etc. This cautious reference to the possible action of other organs fits exactly what we now know of the extreme complexity of puncture glycosuria, which complexity is nowhere more evident than in Macleod's latest contribution to the subject (8). The effect of Bernard's

puncture is dependent upon the integrity of both the splanchnic and hepatic nerves, and upon the presence of the suprarenals; and Cushing (7) has obtained evidence that still other organs, and possibly the pituitary, are involved in it.

As another instance of the important observations which lie hidden in unknown numbers in the older literature, one might quote an experiment in which Pavy, in his search for lesions producing glycosuria, "cut through the crura cerebri," whereupon there followed "a state approaching tetanic rigidity of the whole body." Any such transection above the pons would produce the "decerebrate rigidity" studied thirty-eight years later by Sherrington.

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Reviews, etc.

Books for review should be addressed to The Editor, Gazette Office, Guy's Hospital, S.E. Their price should in every case be stated.

The Practitioners' Vade Mecum, or, How to Cut the Drug Bill. By A. Herbert Hart, M.S. (Bale, Sons and Danielsson.) Third edition.

The preface to the first edition of this book stated that one of its objects was to enable medical practitioners to reduce their drug bill 20 or possibly 50 per cent., and in glowing words the writer pictured what the £20 thus saved could buy. Another of the features recommended for universal use was the systematic adoption of abbreviations. For instance, to save "a world of brain fag," M.A.C., standing for mist. ammon. chlor., is to be written for a prescription for a cough. Briefly, the economy is to be effected by making up one's own preparations in the surgery, and by the systematic adoption of mixtures, etc., made with as little alcohol as possible: thus, liquid extracts are almost entirely recommended instead of the more alcoholic and expensive tinctures, aromatic waters are made by using a very strong solution of the oil instead of by the usual methods. In the latter connection, however, one must demur to the author's recommendation to make an aromatic water by rubbing the oil with magnesium carbonate and cold water. This is very bad pharmacy, because a water so made will contain sufficient alkali to precipitate the strychnine, for example, from a mixture containing that alkaloid, and the result might be extremely unfortunate to all concerned.

The author recommends this edition to the National Health Insurance Commissioners for use under the Insurance Act, but certain features quite preclude this being taken seriously. One of these is that he has adopted official names and given unofficial formulæ for preparations already official, which, if supplied by a chemist under the Act, would render him liable under the Sale of Food and Drugs Act. Thus, if say, glycerin of alum were ordered in a prescription and made up according to the formula on page 22 of this book, the product would certainly be deficient in strength. Liquor iodi. fort. made up as on page 62 would be too strong, for the signs there employed are those usually adopted to indicate the apothecaries' ounce, whereas this preparation, as well as others in the B.P., is made by using the avoirdupois ounce. The formulæ for mixtures constitute the best section in the work, but in three of them the drachm sign is used instead of the ounce sign.

Another feature in which this edition differs from the second is in the introduction of short chapters dealing with proprietary invalid foods, antiseptics, disinfectants, etc. The language used to describe these is not such as one would expect from a member of the medical profession, and one can best end this account by comparing the statement on page 51 that a particular food contains 95 per cent. of casein and 5 per cent. of glycerophosphoric acid with that on the next page, after describing Cornish cream, that "To-day the invalid, the convalescent, and the strong may obtain this Cornish cream in its idealised state as ——."

Materia Medica Tables. By J. A. Jennings. (H. H. G. Grattan.) 1s. 6d. net.

These tables have been compiled with the object of relieving the student from the drudgery of copying some of the matter required by the Conjoint Board in the subject of Practical Pharmacy. They comprise all the drugs required for this examination, with their doses, the galenical preparations made from them, and the doses and strengths of the latter. In addition, there is a posological table of the drugs of the Pharmacopœia classified on an ascending scale. The drugs are arranged alphabetically, and while we can

appreciate the advantages and otherwise of that arrangement, we can find no clue to the system under which the preparations are classified, although the compiler states that it is one that has been found useful in practice. Used as an adjunct to systematic training in this subject, as the compiler intends, these tables should prove helpful.

Diagnosis of Bacteria and Blood Parasites. By E. P. Minett. (Baillière, Tindall & Cox.) 7s. 6d. net.

This book is now in its second edition, and its scope, though not its size, has been increased by the addition of a short account of some of the more highly-developed organisms. It is not a book from which by using it alone the student will learn bacteriology, it is the notes which he should take while doing a course in practical work that will be most useful to him, both at the time and also as a refresher to his memory to be used before an examination.

The arrangement of the book is very good; in the first thirty pages are to be found in their proper order those steps by which a diagnosis of the micro-organism can be made. The chapter on stains is to be recommended to those whose practical work is rather rusty, the steps of the process and the appropriate bottles are named, while irrelevant facts as to the preparation of their contents are not given. Again, in the descriptions of the special reactions, Wassermann, etc., though they would be of little use to a novice who wished to bring off the reaction, yet they are just what is wanted to remind the candidate who would seem to have a practical working knowledge of such things.

To the average student the more complex parasites are mostly so well known by name and so unknown in every other respect that the notes on staining them and preparing films to show them will be very useful, though beyond these two points he will be little wiser than he was before.

Mr. H. K. Lewis informs us that Mr. Louis B. Rawling's popular "Landmarks and Surface Markings of the Human Body" has been adopted as the text-book at the McGill University, Montreal; Queen's University, Kingston; Toronto University, Toronto; and the Western University, London, Ontario.

We have received a copy of a handsomely illustrated booklet entitled "To the Continent," issued on behalf of the Great Eastern Railway. It may be obtained post free from the Continental Manager, Liverpool Street Station, E.C.

PAPERS RECEIVED.—The Hospital, The London Hospital Gazette, St. Mary's Hospital Gazette, Middlesex Hospital Gazette, St. Thomas's Hospital Gazette, Manchester University Magazine, New York State Journal of Medicine, Clinical Journal, Nursing Times.

Athletic Sports.

THE Annual Sports were held at Honor Oak Park, on Saturday, June 7th. Although the weather was fine and warm the attendance was very poor indeed. It is a pity that a little more keenness is not shown at this function which is one of the most sporting and enjoyable of the summer session.

The events were, as usual, keenly contested, and the times were well up to the level of recent years, although no very striking performances were seen.

C. H. Medlock beat his own record for the Long Jump by doing 20 feet 2½ inches. C. L. Curle's 5 feet 4 inches in the High Jump was highly creditable, as was Bowes' 440 yards in 54 1/5 seconds, and H. W. Evans' 101 feet in Throwing the Hammer. Evans again made good his title to the Lucas Challenge Cup, this being the third year in succession in which he has won it.

100 YARDS SCRATCH.—H. W. Evans, 11 3/5 secs., 1; C. L. Curle, 2; R. J. Pickett, 3. Won easily.

HALF-MILE SCRATCH.—E. S. Bowes, 2 mins. 11 1/5 secs., 1; J. R. Barrow-Clough, 2.

PUTTING THE SHOT, HANDICAP.—W. J. D. Smyth, 3½ft., 34ft. 1½ins., 1; A. L. Stokes, scratch, 33ft. 3 1/3ins., 2; W. D. Galloway, 3½ft., 32ft. 7ins., 3.

PUTTING THE SHOT, SCRATCH.—A. L. Stokes, 34ft. 5½ins., 1; A. V. Moberly, 22ft. 7ins., 2; W. J. D. Smyth, 32ft. 2½ins., 3.

100 YARDS HANDICAP.—K. F. McAlpin, 6 yds., 1; C. L. Curle, 4 yds., 2; R. J. Pickett, 7 yds., 3.

120 YARDS HURDLES, SCRATCH.—E. S. Bowes, 19·4 secs., 1; D. A. Bevis, 20·1 secs., 2.

DONKEY RACE.—W. J. D. Smyth, 1; M. B. M. Tweed, 2.

440 YARDS HANDICAP.—E. S. Bowes, scratch, 54 1/5 secs., 1; W. J. D. Smyth, 20 yards, 2. Won very easily.

HIGH JUMP HANDICAP.—R. Quesada, 6ins., 5ft. 8in., 1; C. L. Curle, 2 ins., 5ft. 6in., 2.

HIGH JUMP, SCRATCH.—C. L. Curle, 5ft. 4in., 1; M. B. M. Tweed and C. H. Medlock, 5ft. 2in.

220 YARDS HANDICAP.—K. F. McAlpin, 10yds., 1; H. Mather, 2yds., 2; E. A. Leviseur, 8yds. 3.

440 YARDS HANDICAP (Open to the Staff of School College and Works Department).—Hansen, 1; Ireland, 2.

ONE MILE SCRATCH.—J. R. Barrow-Clough, 5min. 1 3/5sec., 1; N. H. W. Saw, 5min. 4 3/5sec., 2.

LONG JUMP HANDICAP.—E. A. Leviseur, 3ft., 21ft. 1½in., 1; A. K. Day-Lewis, 2½ft., 20ft. 3½in., 2; C. H. Medlock, scratch, 19ft. 10½in, 3.

LONG JUMP, SCRATCH.—C. H. Medlock, 20ft. 2½in., 1; H. W. Evans, 19ft. 3in., 2; C. L. Curle, 19ft. 3in., 3.

120 YARDS HURDLES HANDICAP.—D. A. Bevis, scratch, 1; C. W. W. Baxter, owes 5yds. 2.

220 YARDS SCRATCH.—H. W. Evans, 24 2/5sec., 1; K. F. McAlpin, 2; E. A. Leviseur, 3.

3 MILES HANDICAP.—G. Coutts Williamson, 200yds., 1; J. R. Barrowclough, scratch, 2; N. H. W. Saw, 8yds., 3.

TUG OF WAR.—Won by the holders, the Old Crocks.

440 YARDS SCRATCH.—C. L. Curle, 1; E. S. Bowes, 2.

MILE HANDICAP.—J. R. Barrow-Clough, 5yds., 1; N. H. W. Saw, 30yds., 2; W. J. D. Smyth, 75yds. 3.

3 MILES SCRATCH.—J.R. Barrow-Clough, 16min. 58sec., 1; N. H. W. Saw, 2; G. Coutts Williamson, 3.

The Prizes were presented by Mrs. Harold Chapple who made a very sporting speech which was greatly appreciated. Dr. Fawcett thanked Mrs. Chapple and appealed to men to keep fit and make an effort for the Shield at the Inter-Hospital Sports.

Lawn Tennis.

INTER-HOSPITAL CUP TIES.

Guy's won the Cup again for the sixth successive year. In the first round they beat London and in the second round Middlesex with the loss of only one match, St. Thomas's being beaten in the final by 8 matches to 4. Scores:—

GUY'S v. LONDON.

SINGLES.

W. R. Reynell beat L. Powell	6–4, 6–2
L. A. Graham beat T. B. Batchelor	6–1, 6–1
H. Sharpe beat W. C. Hartgill	6–1, 8–6
R. Curle beat W. B. Cam	6–2, 6–2
R. H. Lucas beat L. C. Somervell	6–1, 6–1
R. Montocchio lost to L. Clive Smith ...	6–3, 5–7, 0–6

DOUBLES.

Reynell and Curle beat Powell and Cam ...	6–3, 6–1
Sharpe and Graham beat Batchelor and Hartgill	6–4, 6–1
Lucas and Montocchio beat Somervell and Smith	6–2, 6–3

GUY'S v. MIDDLESEX.

SINGLES.

W. R. Reynell beat G. Baker	6–1, 6–1
L. A. Graham beat H. Boldero	6–0, 6–0
R. Curle beat E. A. Wilson	6–4, 6–0
H. Sharpe beat W. B. Loveless	6–1, 8–6
R. H. Lucas beat M. L. Loveless	6–3, 6–2
G. H. Hunt lost to J. W. Melhuish	6–8, 5–7

DOUBLES.

Reynell and Lucas beat Wilson and Boldero ...	6–2, 6–4
Sharpe and Graham beat Loveless and Loveless	6–3, 8–6
Hunt and Curle beat Baker and Melhuish	4–6, 6–4, 6–1

FINAL.—GUY'S v. ST. THOMAS'S.

SINGLES.

W. R. Reynell lost to C. Gouldesbrough ...	4–6, 3–6
L. A. Graham beat H. C. Attwood	6–4, 6–3
R. Curle beat W. Burt	6–3, 6–3
R. H. Lucas lost to A. D. Gardner	4–6, 3–6
H. Sharpe beat W. W. Wagstaffe	6–0, 6–0
G. H. Hunt beat R. Hewitt	6–4, 0–6, 6–2

DOUBLES.

Reynell and Lucas beat Gouldesbrough and Wagstaffe	7–9, 6–4, 6–0
beat Attwood and Gardner	4–6, 7–5, 7–5
Sharpe and Graham beat Attwood and Gardner	6–3, 4–6, 6–4
beat Burt and Hewitt	6–1, 8–10, 6–2
Curle and Hunt lost to Burt and Hewitt	6–4, 3–6, 5–7
lost to Gouldesbrough and Wagstaffe	4–6, 7–5, 5–7

Cricket.

THE INTER-HOSPITAL CUP.

GUY'S v. MIDDLESEX.

Guy's were drawn in the first round against Middlesex Hospital. The match was played at Chiswick Park on Friday, May 30th, and resulted, almost on time, in a victory for Guy's by 106 runs. Had Middlesex been able to bat for another 10 minutes the match would have been a draw. The result as it was must be largely attributed to the sterling attack with the ball made by A. F. Rook, who captured 7 wickets for 85 runs. He also took a century in the Guy's innings. A. H. Birks was unfortunate in missing a three-figure score by 2 runs.

GUY'S.

A. B. Bond, c Whitworth, b Whybro	5
A. C. Hancock, b Fischel	41
C. Vincent-Brown, b Bayley	21
L. H. Dixon, c Brice-Smith, b Bayley	54
A. H. Birks, b Bayley	98
A. F. Rook, not out	100
B. Sampson, lbw, b Blackmore	31
G. W. M. Andrew, c & b Melhuish	13
H. Sterne-Howitt, not out	8
Extras	26
Total (for 8 wickets)	397

A. H. Harkness and F. Biddle did not bat.

MIDDLESEX.

A. S. Whitworth, b Sterne-Howitt	7
P. W. Symons, c & b Rook	70
R. V. Hudson, c Dixon, b Rook	33
P. S. Bayley, c & b Sampson	4
C. H. Fischel, b Harkness	6
T. W. Melhuish, c & b Rook	3
W. Brice-Smith, b Rook	62
L. G. Blackmore, b Rook	72
R. H. V. Whybro, not out	15
B. M. Tuke, b Rook	2
R. Fagan, st Birks, b Rook	0
Extras	17
Total	291

SEMI-FINAL.

GUY'S v. ST. THOMAS'S.

Coming into the second round of the Cup Competition, Guy's met St. Thomas's at Winchmore Hill on Thursday, June 12th. Our opponents batted first, and must have been not a little surprised at finding that they were all out, a quarter of an hour before lunch for the small score of 116. In that quarter of an hour, however, our first pair got out, only 10 runs showing on the board. On resuming after lunch, our batsmen showed complete inability to cope with the slow deliveries of Meakin, and 7 wickets went down for 41 runs. Harkness now joined Andrew at the wickets and at once opened by playing Meakin twice to the four boundary. He treated Morcom similarly a few minutes later. With Andrew playing confidently at the other end, things were beginning to look very much brighter for Guy's. The end came, however, when Harkness hesitated with an off-drive, the ball finding mid-off's hands; and Andrew was dismissed soon after. The total of 83 cannot be con-

sidered as anything more than a disgrace, as Guy's are really a strong batting side this season.

ST. THOMAS'S.

C. W. Sparks, c Vincent-Brown, b Harkness	21
L. Meakin, c Bond, b Biddle	9
—. Gardiner-Hill, c & b Harkness	7
G. Cranston, b Dixon	40
A. F. Morcom, b Biddle	0
D. M. Gibson, c Bond, b Biddle	13
A. R. C. Doorly, b Dixon	2
V. C. Prunell, c & b Biddle	6
L. W. Shelley, c Birks, b Biddle	2
M. R. Atkinson, b Biddle	5
H. J. Fry, not out	2
Extras	9
Total	116

GUY'S.

A. B. Bond, b Meakin	3
A. C. Hancock, b Morcom	2
C. Vincent-Brown, lbw, b Meakin	4
L. C. Dixon, b Morcom	7
A. H. Birks, b Meakin	3
A. F. Rook, lbw, b Meakin	11
G. W. M. Andrew, c Morcom, b Cranston	20
B. Sampson, b Meakin	3
A. H. Harkness, c Atkinson, b Cranston	27
H. Sterne-Howitt, not out	0
F. Biddle, c Morcom, b Cranston	0
Extras	3
Total	83

PAST v. PRESENT.

Played at Honor Oak Park on Saturday, June 14th, and resulted in a win for the Present by 79 runs. Considering the difficulty of getting a Past side together, the team that ultimately took the field was a very fair one. Morres served them well with the bat as also did Tooth, the fast trundler from Somerset, with the ball. Quite a feature of the day also was the "knock" by J. G. Saner. He and Morres were the only double figure takers for the Past.

THE PAST.

T. Morres, b Dixon	35
H. Bookless, c Bond, b Biddle	4
D. C. Covell, b Dixon	1
H. C. Rook, b Dixon	1
H. Lee, c Dixon, b Biddle	0
M. M. Munden, b Dixon	3
E. S. Digby, lbw, b Biddle	6
H. Chapple, c Lucas, b Biddle	0
F. D. Saner, b Biddle	6
J. G. Saner, b Dixon	18
H. Bastard, not out	7
F. Tooth, b Biddle	7
Extras	6
Total	94

THE PRESENT.

A. B. Bond, st Munden, b Chapple	9
A. C. Hancock, b Tooth	34
C. Vincent-Brown, b Chapple	15
A. H. Birks, b Tooth	1
L. H. Dixon, c Covell, b Tooth	35
A. F. Rook, b Tooth	14
G. W. M. Andrew, c Covell, b Bookless	5
B. Sampson, c Sub., b Rook	18
C. Curle, c & b Rook	5
H. Lucas, b Tooth	12
F. Biddle, not out	6
A. H. Harkness, b Tooth	4
Extras	15
Total	173

Pass List.

Oxford University.

The Degree of D.M. has been conferred on R. C. Mullins, M.A., M.B., B.Ch.

PAPERS RECEIVED.—The Prescriber, University College Union Magazine, The Hospital, St. George's Hospital Gazette, Manchester University Magazine, St. Bartholomew's Hospital Journal, Nursing Times.

Births.

GRAY.—On June 13th, at "Loch Lomond," North Circular Road, Dublin, to Captain and Mrs. A. C. H. Gray, R.A.M.C., a son.

STOTT.—On May 23rd, at Ootacamund, India, the wife of Captain Hugh Stott, M.B., B.S., I.M.S., Surgeon to His Excellency the Governor of Madras, of a son.

VISICK.—On May 30th, 1913, at 19, Gloucester Road, Regent's Park, London, N.W., the wife of Hedley C. Visick, L.D.S. Eng., of a daughter.

Marriages.

CARRUTHERS—FORBES.—On June 2nd, 1913, at Southwark Cathedral, by the Rev. A. E. Popham, Norman Stuart Carruthers, M.R.C.S., L.R.C.P., The Firs, Reedham, Norfolk, youngest son of the late Joseph Carruthers, of Moffat, N.B., to Elizabeth, second daughter of John Forbes, of Pitlochry, N.B.

KEATES—STUBBS.—On 10th April, 1913, at Dera Ghazi Khan, Punjab, by the Rev. E. S. Thomas, Captain H. Crewe Keates, M.D., I.M.S., eldest son of H. T. Keates, Esq., of Petersfield, Hants, to Ivy, second daughter of T. B. Stubbs, Esq., of Rangoon, Burma.

MILLS—COLLINGE.—On June 12th, at St. Olave's, Southwark, by the Rev. Herbert Williams, Rector of Horselydown, Claude Harry, third son of Mr. and Mrs. W. H. Mills, of Eaton Grange, Parkstone, Dorset, to Mary Victoria, daughter of the late Mr. and Mrs. Robert Collinge, of Oldham, Lancashire.

ROBERTSON—WESTON.—On June 8th, 1913, at St. Mary's, Portsea, by the Rev. Paul Green (cousin of the bride), Ernest Guy Robertson, L.D.S. Eng., of Southampton, to Katherine Dorothy, daughter of Dr. and Mrs. Robert Ambrose Weston, of Portsmouth.

YERBURY—KELSON.—On March 22nd, at St. Margaret's, Oxford, Edgar O. Yerbury, L.D.S., to Constance Mary, elder daughter of Mr. and Mrs. Kelson, of Oxford.

Deaths.

SMITH.—On June 3rd, 1913, at Cerrito, Parkstone, Dorset, the Rev. Francis Smith, M.A., M.R.C.S., L.S.A., M.D., aged 90.

TARGETT.—On May 26th, 1913, James Henry Targett, M.S., F.R.C.S., Senior Obstetric Physician to Guy's Hospital, aged 51.

G. T. M.

GUY'S HOSPITAL GAZETTE.

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Passim.

THE Guy's Hospital Ladies' Association, to whose good work we referred recently in these columns, is endeavouring to raise a sum of £500, with which to endow a Cot in the Hospital, in celebration of its twentieth birthday. This endowment fund, it must be clearly understood, is a sum over and above the yearly contributions which the Association sends to the Hospital—contributions which this year support no less than six beds and two cots. Over £200 has already been collected, and strenuous efforts are now being made to obtain the balance as soon as possible.

In furtherance of this object, Mrs. Stanley Mason, the energetic secretary of the Banstead, Epsom, and Surrey Branch, is organising a Quotation Calendar, and as her letter in the correspondence column shows, she earnestly solicits the help of all who are interested in Guy's Hospital. The plan is simple and straightforward, and will, we firmly believe, be completely successful. All you have to do is to think of your favourite quotation, write it in the space provided on the inset which will be found in this number, and send it, together with two or more shillings, to Mrs. Mason or any member of the committee. Your quotation, which may range from the sublime to the (almost) ridiculous, will then be printed against some suitable date in the year, and you will in due course receive a copy of a very tasteful and appropriate Guy's Calendar. You may, if desired, have your name or pseudonym printed beneath your quotation.

MRS. MASON has already received a large number of contributions, but she still requires several hundred more, and we confidently expect that Guy's men and nurses will soon complete the required total. The amount asked is so small and the object so praiseworthy that even the most inveterate grumbler can find no excuse for not sending in his mite. And when we have sent our own contributions in, have we not all mothers and cousins and aunts who can be bled in the good work? "The GAZETTE expects that every man (and nurse), etc. . . . ."

IT seems that at present a blight has fallen on almost every form of social activity in our hospital life. From all sides we hear the same tale. It is a constant and wearisome tale of slackness. Whenever two secretaries are gathered together the talk is always of the lack of keenness and the apathy of the club members. But we are at present attacked a little by the same disease, and so will not pursue the matter further until after the holidays.

THE latest complainant is the Chaplain. The Choir which, but a year or two ago was a flourishing institution, has fallen under the fatal curse. A glance at the Attendance Book a few

days ago showed an appalling number of dates with the laconic but pathetic words "No Choir" written across them. The other entries seemed to consist chiefly of one, or at most, two names. We earnestly hope that there will shortly be a better attendance in the Choir on Sundays. There must be numbers of men with voices sufficiently good, and with other inducements to turn up, whose only excuse is slackness.

As we are on the subject of the want of keenness among the men, it is pleasant to be able to record the very successful Swimming Sports which took place on June 26th, in the Southwark Baths. The entries for all the contests were very good, and a large and appreciative crowd turned up to watch. It was particularly pleasant to see so many nurses, and so many of the Staff present.

WHAT we have been saying about the apathy of the men does not apparently apply to the nurses. We have just learned of the existence of the Tabard Branch of the National Union of Women's Suffrage Societies (non-political and non-militant). The Branch has a membership of nearly forty nurses, with Lady Perry as the President, and the Matron as Chairman. The members are, we understand, very keen, and have been addressed by many prominent leaders of the suffrage movements. Among recent speakers have been Miss Maud Royden, Mrs. Swanwick, Miss Geraldine Cook, and Mrs. Corbett Ashby. Mrs. Henry Fawcett, LL.D., is going to address the Society early in July. It is to be hoped that an opportunity will be given to men to be present at the meeting.

MANY old Guy's men will be glad to hear that the Clinicals' Book has been recovered after a very lengthy disappearance. It was discovered under a pile of old books in the College, in Gray's Lodge. Whether it has lain there in peaceful oblivion all the time, or whether that situation was chosen as unobtrusive means of returning it, we know not, nor does it greatly matter. Suffice it, that like little Bo-Peep's Sheep it has come home again. We would remind those men who did Clinical during the absence of the book, that no time should be lost in filling up the empty pages.

THE results of the recent examination for the Degree of M.C. (Camb.), are very gratifying to Guy's. Out of nine candidates who presented themselves only two were successful, and both, Messrs. L. Bromley and H. L. Attwater, are Guy's men. All the M.C.'s granted during the past year have been obtained by Guy's men. Congratulations, gentlemen.

THE eargerly expected list of Junior Staff Appointments has at length appeared, and rumour is now at rest for a few short weeks —of course, only recuperating for another long campaign during the coming year. A full list will be found elsewhere, but we may summarize here the chief changes which have occurred. Dr. G. H. Hunt has been promoted to the Staff as Fifth Assistant Physician to fill the vacancy caused by Dr. Pitt's impending retirement. Mr. Harold Chapple has been appointed Obstetric Surgeon, thus filling the vacancy caused by Mr. Targett's death. Mr. W. H. Trethowan has been appointed Surgeon in charge of the Orthopædic Department, which appointment Mr. R. P. Rowlands is resigning.

The new Medical Registrars are Messrs. E. P. Poulton, M.B. Oxon., M.R.C.P. (H.P. to Dr. Hale White, April to October, 1911); H. W. Barber, M.B. Cantab. (H.P. to Sir Cooper Perry, November, 1911, to May, 1912); and T. B. Heaton, B.M. Oxon. (H.P. to Dr. Hale White, October, 1912, to April, 1913). Mr. J. G. Saner becomes R.S.O., and his place in the Dissecting Room is taken by Mr. L. Bromley. Mr. A. H. Todd, F.R.C.S. (H.S. to Mr. Dunn, August, 1912, to February, 1913, and Ophthalmic H.S., February to August, 1913), is appointed Surgical Registrar in place of Mr. Bromley. Mr. Geoffry Marshall, M.B., B.S. (H.P. to Dr. Pitt, August, 1912, to February, 1913), becomes Demonstrator of Physiology in place of Mr. Poulton. The post of Obstetric Registrar, vacant by Mr. Chapple's promotion, is filled by Mr. A. J. McNair, M.B., B.C. (H.S. to Sir Alfred Fripp, May to November, 1912, and

R.O. to Mr. Targett, January to July, 1913). To all our hearty congratulations. *Floreant!*

Our new Assistant Physician, Dr. G. H. Hunt, is a man of Kent, having been born at Chislehurst. He was educated at Rugby, whence he went to Christchurch, Oxford. He first came up to Guy's in October, 1907. He dressed to Sir Arbuthnot Lane, and such was his keenness for medicine, that after doing Clinical, he passed straight on to O.P.O. without troubling himself with anything so purely surgical as A.H.S. He was Dr. Shaw's H.P. from January to July, 1911. He passed his Oxford Final in 1910, and obtained the M.R.C.P. in April, 1912. Immediately on finishing his House Appointments he was appointed Medical Registrar in October, 1911, which appointment he relinquishes on taking up his new duties.

Mr. Harold Chapple hails from what some of us consider to be the best of all the Colonies. He was born in Adelaide, South Australia, and was educated there, first at Prince Alfred's College, and then at Adelaide University. Before coming up to Guy's, however, he spent some time in Cambridge (St. John's). He entered the Hospital in 1905, and after being Clinical and O.P.O., he was H.S. to Mr. Lane, July, 1909, to January, 1910. He took his M.C. (Camb.) in 1911, and the F.R.C.S. in 1910. He was appointed Obstetric Assistant in October, 1911, and has been doing Mr. Targett's work during his long illness. Advance Australia!

The new Orthopædic Surgeon, Mr. W. H. Trethowan, is a Cornishman, having been born at Cawsand. He was educated at Plymouth, and entered Guy's in 1901, gaining the Junior Entrance Science Scholarship. He obtained a Gold Medal with Honours in Medicine, Surgery, and Midwifery, in the M.B., B.S. Lond., in 1906, and the F.R.C.S. in 1912. He held successively the posts of Clinical O.P.O., H.P. to Dr. Pitt. R.O. and R.M.O.B., 1908 to 1910. He was appointed R.S.O. in 1910, and held that post till early in 1912, since when he has spent most of his time in Sweden and Germany, studying Orthopædics.

Pass List.

University of Cambridge.

Degrees Conferred.

M.C.

H. L. Attwater, F.R.C.S. | L. Bromley, F.R.C.S.

M.B.

A. J. McNair. | C. Warner. | A. M. Zamora.

B.C.

A. J. McNair. | C. Warner. | A. M. Zamora.

Third Examination for Medical and Surgical Degrees (Under Old Regulations).

Part I.—Pharmacology and General Pathology.

A. S. Seabrooke. | J. L. M. Symns.

Part I.—Surgery and Midwifery (Under New Regulations).

E. S. Taylor.

University of Oxford.

Second M.B. Degree.

Pathology.

L. R. Broster. | C. P. Symonds. | T. A. Townsend.

Forensic Medicine and Public Health.

F. A. Hampton. | W. H. Ogilvie.

Medicine, Surgery, and Midwifery.

F. A. Hampton. | W. H. Ogilvie. | J. F. Venables.

Royal College of Surgeons of England.

Final Fellowship.

A. H. Todd, M.B., B.S., B.Sc.

Society of Apothecaries.

Midwifery.

H. N. Eccles.

Change of Address.

Captain H. F. Joynt, M.B., B.S., R.A.M.C., from Military Hospital, Bloemfontein, to Military Hospital, Wynberg, Cape Province.

M. K. Nelson, M.R.C.S., L.R.C.P., from Cherry Valley, Marlborough Park, Belfast, to 52, Botanic Avenue, Belfast.

H. F. Vandermin, M.D., from 5, Peckham Grove, Peckham, to Silverton, Enfield, Middlesex.

Jenner Plomley, to 51, Fife Road, Kingston-on-Thames, Surrey.

The change of address for Dr. J. H. Busteed published in last issue of the Guy's Gazette is incorrect and should read—"from Stuart Lodge, Highcliffe-on-Sea, to Bungay, Suffolk.

Clinical Demonstration by Dr. Shaw.

IN accordance with the new scheme of Clinical teaching recently adopted by the School, Dr. Shaw substituted for his formal clinical lecture on Wednesday, June 4th, a demonstration on selected cases. Four cases were submitted, the demonstration lasting about three-quarters of an hour. The following are brief notes of the various cases.

1. *Raynaud's Disease.*—A man, 22 years of age, who had been affected by various indications of the disease for five years. He belonged to the intermediate group in the classification of types of the disease in Osler and McCrae's system, *i.e.*, he had actual destructive lesion of fingers and toes, but no vital and disabling gangrene of extremities. At no time had there been any indications of urinary changes such as hæmoglobinuria or albuminuria, suggesting spasm of renal vessels, but there were symptoms suggesting affection of cerebral arteries. The cause of his admission on this occasion was a sudden attack of syncope in the street, and he described frequent "faint" sensations followed by frontal headache. He had formerly been in the hospital in December, and had then shewn characteristic attacks of dead fingers. When previously under Dr. Shaw last August and again now during a spell of warm weather, typical attacks were not in evidence. The four stages easily recognizable as the result of vascular spasm, might be clearly indicated by the colours white, blue, red, and black; syncope asphyxia, hyperæmia and gangrene. The patient had obviously had the *black* stage as indicated by the scars of his gangrene—his report in December speaks of his dead *white* fingers. At present there is a more or less constant condition of *blueness*, occasionally giving way to a more actual *redness*. Anything which promotes circulation in the extremities is useful, and he has at various times found comfort from Bier's bandages, galvanic baths, and electrical stimulation. His improved condition in hot weather suggests that he might benefit by emigration to a semi-tropical climate, but various philanthropic agencies to which application has been made are, perhaps, not unnaturally indisposed to run the risk of responsibility for the experiment. When the disease was first recognized the proposal would have been fully justified.

2. *Diffuse pigmentation.*—A boy, aged 11, was admitted a month after an attack of tonsillitis for what appeared to be a slight attack of articular rheumatism with transient heart murmurs. The point of interest lies in his complexion, which is so dark as to raise the question of Addison's Disease. One might almost pass the condition as a mere congenital peculiarity, but for the mother's confident assertion that she has noticed a marked change in his colour in the last few years. There is no pigmentation of the mucous membranes and no marked increase of pigment over parts usually subjected to pressure.

A point which has prevented the mother's statement as to change being disregarded is the marked appearance of ephelis ab igue on the boy's shins. For a boy of 11 to scorch his shins by sitting in front of the fire indicates a prolonged period of ill-health. Dr. Shaw said he did not know how long it would take to cause the ephelis demonstrated in this boy, but could hardly believe it to be possible for it to be produced in the month's illness that had elapsed since the tonsillitis. The feeling of coldness which so commonly accompanied the low blood pressure of Addison's disease was of interest in this respect, as also was the question whether the pigmented condition of ephelis would be more easily and rapidly produced if the suprarenal capsules were diseased. It had been stated that it was a characteristic feature of Addison's disease that blood pressure could be raised by the administration of suprarenal extract, and Mr. Perceval, the Clinical Assistant in the case, was endeavouring to investigate this point. Information was being sought as to the natural variations in blood pressure in the patient, so that a customary rise should not be attributed to effects of the drug. Two points had at present been established, that the patient's blood pressure was on the whole lower than that of another boy of his age in the ward, and that there was much greater variability from time to time than in control patients. Von Pirquet's reaction had been tried and was negative with 1 per cent., 4 per cent., and 6 per cent., but positive with 64 per cent. In the constantly shifting values given to this reaction in its many forms, the clinical observers did not know what importance to attach to this observation. No other likely cause for the pigmentation can be discovered, and at present the verdict is "not proven."

3. *Polycythæmia.*—A rivetter, æt. 58, presented a most striking appearance on account

of the colour of his face and skin generally. The clinical assistant described it as "a very marked brick-red colour with some cyanosis." Although always a teetotaller or moderate drinker, his complexion had been a disadvantage to him in seeking employment for the last twelve years, during which time the condition has persisted. He can do a good day's work as a rivetter, but has a good many minor indications of ill-health. Headache, giddiness, trembling fits in the early morning, dyspnœa on exertion, tinnitus aurium, and progressive deafness. He once had pain and swelling in one foot, and has several times bled rather severely—once after tooth extraction, once from a punctured wound of the lip, which bled continuously for 78 hours, and quite recently from some oral source which was not discovered. This oral hæmorrhage was the reason for his seeking admission, and was said to have started as the result of straining at his work. He thinks he lost a pint of blood.

The case seems to be a typical one of Polycythæmia with cyanosis and splenomegaly, the long name it had a few years ago, now shortened to Erythræmia. Neither name gives us any indication as to the real nature of the disease. The patient has 10,000,000 red cells per c.mm., and 7,500 white. The red cells are of normal shape, hæmoglobin 125 per cent. The artery is very thick and tortuous, the B.P. 175, the heart moderately enlarged. The spleen is easily felt an inch below the margin of the ribs. It is unduly hard. An interesting question arose in this case as to whether the bleeding, which was the immediate cause of inability to work, was due to an accident or to disease. The payment during incapacity, to which the patient was undoubtedly entitled, would come from a different source in accordance to the answer given to this question. The patient and the medical profession were put to very unnecessary delay and trouble in settling points like this. It would be to everyone's advantage if the only question to be settled was: "Is the patient unable to work as the result of physical disability?" To that we should give an unhesitating answer, yes.

4. A Bilious Attack was the illness for which this patient, a girl, æt. 8, was brought by the mother, though she was admitted to the ward with the more dignified diagnosis of "cyclic vomiting." Such a case does not often find its way into clinical, and this unusual event was partly attributable to the severity of the attack, and partly to the fact that the child's mother was already an inmate of the ward. That such attacks are commonly produced, as the public think, by immediate indiscretions in diet is more than doubtful. Persistently inappropriate diet in a child with some primary defects in its chemistry may no doubt produce periodical bouts of headache, vomiting, and pyrexia. An excessively nitrogenous diet in a child with gouty inheritance may be responsible for attacks of this sort, and may be called migraine, cyclic vomiting, or food fever, according to the predominant symptom. Such an origin is much commoner amongst the wealthy than the poor, who, perhaps, have less of this sort of inheritance, and certainly less opportunity of excessive indulgence in a diet too rich in meat.

Dr. Shaw said that in accordance with the principle, that he thought should never be neglected, of examining the eyes of all cases in which periodic sickness, vertigo, or headache was a prominent symptom, Mr. Ormond was asked to see the case, and found a considerable degree of hypermetropia in both eyes, with some astigmatism in the left.

It is, therefore, concluded that the case belonged to the most important, if not the commonest, group of Bilious Attacks, viz., those due to error of refraction, most important because it could be easily and perfectly cured by one simple remedy, and by that remedy alone.

Chapel Committee.

Annual Report for year ending Easter, 1913.

THE Chapel Committee have pleasure in presenting the following report for the year ending Easter, 1913.

The usual services have been maintained, and it is encouraging to notice that the daily celebration of the Holy Communion has not once failed from lack of worshippers. The extra services at Advent and Lent were made attractive by some of the best known preachers of the day and were well attended. At Christmas Mr. Clive Carey resigned his position as Organist and Choir Master, and the Committee wish to record their appreciation of the care, willingness, and skill with which he carried out his work. Mr. Dennis Browne, Mus. Bac., of Clare College, Cambridge, has been appointed to succeed him. The Committee regret to say that the attendance of the members of the Students' Choir has been very poor, for many Sundays there has been no choir at all. Mr. Evelyn Scott has consented to act as Choir Secretary for the ensuing year, and the Acting Chaplain is appealing to the Students by means of a letter in the columns of the GUY'S GAZETTE.

Some Notes on Surgery in America.

3. Chicago.

BY E. G. SCHLESINGER.

Chicago is the home of three Universities: the North-Western, the Illinois State, and the Chicago University, and in consequence the work is very much scattered. The system, however, which prevails fairly generally in America by which the surgeon does his private operating in the same hospital in which he does his charity work enables a far greater concentration to be obtained than is possible under the English scheme. The same assistants who help with "clinic" cases usually also help with private work, and consequently the operating room routine runs, as a rule, remarkably smoothly. Further, a great deal more operating work is done here in a given time than at Guy's, a fact which does not depend upon any greater rapidity in the operator, but which is made possible by an almost complete elimination of the tedious waits between cases. The "sewing-up" is usually done by the assistant at one table, while the operator has begun a second operation at another table. Again, the instruments, towels, sponges, etc., are kept in the *theatre,* and are not brought in from the various wards, while the instrument tables are kept constantly supplied with all the instruments which may, by any possibility, be required. That this system is economical of money as well as of time is obvious when it is remembered that the nurse who is responsible for the amount of material used is also in charge, as a "scrubbing up" assistant, of the instrument table during operations.

Dr. J. B. Murphy, at the Mercy Hospital, is a man of high originality, as well as of operative ability, and is at the same time a great clinical teacher. While his clinic covers every type of case, I was more particularly interested in his bone and joint work, of which I was able to see a great deal. As is well known, Murphy has developed the treatment of bony ankylosis of joints by means of arthroplasty, which consists in reconstituting the diseased joint by shaping the ends of the bone as nearly as possible to their normal form, and then in turning into the newly-formed joint cavity a flap of deep fascia.

I saw a large number of his results from this operation, and in non-tuberculous cases they were uniformly excellent. Murphy himself hesitates greatly in advising operation to tuberculous cases, even when many years quiescent, since the results appear to be by no means certain, these patients showing a great tendency to the formation of hæmatomata which are very prone to break down. In operating on the knee-joint for ankylosis, after shaping and lining the ends of the femur and tibia, he divides the patellar attachment of the vasti muscles, and the ligamentum patellæ, and then reverses the position of the patella and its superficial bursa, so that its articular surface lies beneath the skin. The vasti muscles are then re-attached to the side of the quadriceps tendon, which is twisted on itself, and the ligamentum patellæ is sewn to the patella, without, in the cases which I saw, any impairment of function.

In deciding whence to obtain the best nourished fascial flaps, Dr. Murphy has availed himself of an ingenious method which I would recommend to the notice of those in charge of the anatomical department. The arteries of the limbs of a cadaver are forcibly injected with an X-ray opaque solution (bismuth or lead) and X-ray plates are taken of the various joint regions. In this manner the ramifications and anastomoses of the vessels are shown in a general and detailed way in relation to the bones, which no amount of dissection can equal.

In operating on the shoulder-joint, either for ankylosis, or, as in a case which I saw, for fracture dislocation, Dr. Murphy uses a method of approach which I believe is new. An incision is made between the pectoralis major and the deltoid, and the coracoid process is exposed. This process is now cut through and it and its attached muscles are thrown downwards, thus obtaining a very free exposure of the joint region.

At the end of the operation the coracoid is replaced in position and fixed with a nail or a screw. A somewhat similar method is used in arthroplasty of the hip-joint. Here the great trochanter is sawn off, and it and its attached muscles are thrown upwards. The joint is then reconstituted, a fascial flap of fascia lata is turned into the cavity, and the trochanter and its muscles are refixed in their normal position by means of a screw.

In operating on the elbow-joint, great care is taken to reconstitute the radio-ulnar joint as well as the humero-ulnar joint cavity.

Dr. Murphy has had much success in the treatment of chronic arthritides by injection of a 2 per cent. solution of formalin in glycerin. About 20 c.c. of the solution are injected, and the patient is kept in bed with extension on the joint. The injection is repeated at intervals of about ten days, until the fluid drawn from the joint shows a bloody reaction. The treatment is then stopped, but extension is maintained, and in a few days the joint reaches normal. This treatment is applied to cases of traumatic and gonococcal arthritis, and to certain cases of very chronic tuberculous arthritis. The same method, combined with aspiration, has been used for cases of pneumococcal empyemata, particularly in bad cases where operation would involve great risk to life. The injections, combined with aspiration, are continued until

only a blood-stained clear fluid is withdrawn, and in some cases seem to show very good results. It is very important that the formalin and glycerin solution should be freshly prepared at least twenty-four hours before use. This method is, whenever possible, accompanied by the use of autogenous vaccines.

I also saw a number of bone-plating and bone-grafting cases. The bone grafts were usually autogenous from the patient's own uninjured tibia. They were used in cases of old ununited fracture and were applied either as medullary splints or were fixed to the two fragments externally by wire. I do not think that this method of using bone grafts is as satisfactory or as logical as that which I saw employed by Dr. Henderson who has charge of the orthopædic clinic at Rochester. He first cuts out a splint of bone of sufficient length from the one fragment, cutting right through to the medullary cavity. A gutter, which also reaches the medullary cavity, is then cut in the other fragment, and the bone graft is slid into position, bridging across the ununited fragments. This method has the advantage that it does not necessitate excessive handling of the bone graft, and, further, exposure of a healthy bone with its attendant risks is avoided.

Dr. Murphy holds very strongly to the traumatic origin of malignant disease, and believes that sarcoma develops as the result of a single trauma, which is never severe enough to cause a fracture, and that carcinoma is the result of a number of not very severe traumatic stimuli, and he shows a large number of clinical histories in support of this contention, which, however, did not appear to me to be very tenable.

In dealing with cancer of the breast, this operator does not remove the pectoral muscles, holding that recurrence, if it takes place, does not take place in the muscles. While this may be true in Dr. Murphy's experience, I do not believe that other surgeons would agree with him, and I have not seen any other operator in the States who follows this practice.

I was unfortunately able to see less of Dr. Ochsner's work at the Augustana Hospital than I could have wished, but gained an impression of him as a very great surgical thinker. His operative technique is unconventional in that he wears neither mask, cap, or gloves, but he gets as good results by his method as other men do by theirs, a fact which serves to emphasize the truth that there are more ways than one of doing a thing and of doing it well.

Dr. Ochsner's views on the operative treatment of appendicitis are interesting. Like almost all American surgeons, he operates on cases seen within the first twenty-four hours without delay, but cases which come to him later he puts to bed, starves absolutely, and operates on at the end of a week or ten days. He states that with this procedure the acute condition almost invariably subsides, and I saw some very interesting cases illustrating this principle.

Dr. Nelson Percy, who is also at the Augustana, showed me a number of patients on whom he had performed ileo-colostomy. He has performed this operation, both for stasis and for its sequelæ, such as rheumatoid arthritis, in over a hundred cases, and expressed himself as very well pleased with the results. I saw him do the operation for a case of intractable migraine associated with marked intestinal stasis in which all other measures had been tried and had failed. I was impressed with the extremely efficient way in which the intestines had been emptied before operation, and found that this was due to the use of very large doses of castor oil before the operation, as much as two or even three ounces being given on two or more occasions before the date of operation.

In doing appendicectomy, Dr. Percy is particular not to ligature the stump of the appendix, since he holds that the ligature is liable to become encysted in the wall of the cæcum, and thinks that this is often responsible for the transient pain in the cæcal region felt after removal of the appendix. He controls bleeding carefully by putting a double stitch round the base of the meso-appendix when inserting his purse-string suture. I saw Dr. Percy operate on a case of infected ruptured ectopic gestation, which proved to contain a fœtus of about three and a half months. The operation was far from simple, and it was performed with great skill and good judgment. Dr. Percy has done a great deal of bone-plating work, and showed me a number of X-ray pictures of his excellent results.

One cannot but be impressed with the large amount of experimental work in surgery which is being done in America, and at almost all the large surgical clinics there are a number of workers, usually operating surgeons, engaging at the same time in laboratory work. This is very true of Chicago, where I saw much interesting work along this line. Dr. Behk has made the instructive observation that in dogs in whom an Eck's fistula had been established, ligature of the common bile duct failed to produce jaundice, although in control animals without an Eck's fistula, ligature of the duct was speedily followed by an intense jaundice.

Dr. Behk's method of making an Eck's fistula was extremely ingenious, since the circulation in the portal vein and the vena cava was not disturbed during the operation. The two veins were first united for the required distance by a continuous suture. A strong silk thread was then passed on a needle into the lumen of the vena cava, and out again about half an inch higher up, and was then passed through the lumen of the portal vein for a similar distance. Another continuous suture now united the veins superficially to the silk thread which traversed their lumen. A fine purse-string suture was placed around the point at which the silk thread emerged from between

the continuous sutures, and was left untied. By means of a sawing movement the silk thread was made to cut its way out of the veins, and the purse-string suture was quickly tied, the anastomosis being thus established. I do not know whether this method of performing veno-venous anastomosis will have any application in human surgery, but it offers a way of getting over the difficulties of a temporary stoppage of the circulation which is otherwise necessary for this operation.

Dr. Cubbins is another very able surgeon in Chicago, who allowed me to see some very interesting cases. He is carrying out research work on the relations between intestinal stasis and goitre, and showed me two dogs with considerable goitrous enlargement of the thyroid, the size of whose glands had been reduced by more than one-half subsequent to the formation of a cæcal anus. He also showed me a patient in whom a large goitre had disappeared subsequent to the performance of ileo-sigmoidostomy.

Dr. Bevan has a large clinic at the Presbyterian Hospital, but I was unfortunately able to see him operate on only one case, a carcinoma of the breast, for which he performed a moderately extensive excision. He has devised a method for the fixation of dislocations of the outer end of the clavicle, which seems able efficiently to control this troublesome displacement. A pad is placed in the axilla, or a felt splint is attached to the forearm, extending well back to the elbow, which is flexed. A Martin's rubber bandage is then passed lightly over the point of the shoulder and the elbow, and is left in position, the dislocation being thus firmly and constantly controlled.

I saw what to me was a novel and interesting plastic operation performed by Dr. Kenavel. The case was one of an old burn of the palm, with extensive scarring and contracture of the fingers. The skin and scar tissue were carefully dissected off the front of the fingers and palm, and the fingers straightened. A pocket of skin and subcutaneous tissue was then made in the buttock, and the hand, palm forwards, was tucked into it. Holes were cut for the tips of the fingers to protrude, and the cut edges of the skin of the fingers were sewn to the edges of the holes in the gluteal pocket. The arm was fixed in position by a plaster cast, which was to remain on for ten days, after which the gluteal flap would be detached and shaped to the fingers.

I saw a case in which this operation had been previously performed, and although a little suppuration had taken place in the gluteal pocket, the result was very satisfactory.

Although not exactly surgical, no visit to Chicago is complete without an inspection of the stock-yards, where uniformed guides conduct the visitor through huge abattoirs where live pigs are converted into sausages with mechanical precision and in about fifteen minutes, and where bellowing oxen melt into carefully-trimmed joints in about the same time. The place is conducted with scrupulous cleanliness and humanity, and, as an example of organised, time-saving labour, it is unique.

The Plate in Dental Radiography.

BY EDWARD W. H. SHENTON.

The obvious limitations of the photographic film, when used inside the mouth, has led me to work out the possibilities of plates. A film can be used with more or less success for the upper central teeth, but elsewhere, to my way of thinking, it leaves much to be desired.

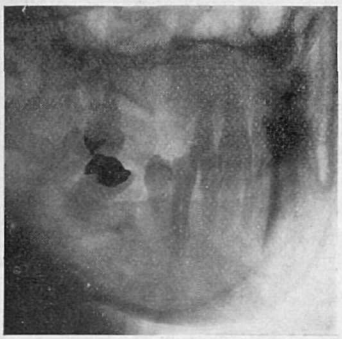
For many years the lower wisdom region only has been successfully examined with a plate placed externally, but I hope to show by the appended illustrations, that almost every region can, with care and skill, be better shown on a plate than on a film.

The film is very popular because it is so easy to manipulate, but the distortional errors due to its bending, and the difficulty of keeping its surface parallel with the tooth's long axis, disqualify it for scientific investigation. Some film photographs are very pretty, but, if they are not true, they are of no real value. Only those who have experimented with photography on a curved surface can realize the absurd distortion to which the image is subjected. Perhaps the looking glass with a wavy surface is a good parallel. Small plates cut to shape would be very much better for dental work, but it is no easy matter to cut plates to shape in the almost total darknes which the safety of the rapid emulsion demands.

Then the internal shape of the mouth is such a variable quantity, and it is often impossible to show the roots of lower teeth because the floor of the mouth is too high. With upper teeth it is generally necessary to slope the film well up into the palate to get in the apex, hence a foreshortening of the shadow of the tooth.

With the plate used externally these objections disappear. The technical difficulties are very great, and for a long time it seemed almost impossible to adjust the head in relation to the tube so that one row of teeth cast an unobstructed shadow upon the plate. Constant practice has, however, overcome these difficulties as the accompanying radiograms will demonstrate.

Only the dentist, who makes use of radiography, and his radiographer, realize the prevalence of septic foci in unsuspected regions, and what is virtually an X-ray chart of the upper and lower jaws should, in my opinion, be made in all cases where such a septic lesion would account for otherwise unaccountable symptoms. Undoubtedly it entails much work, but the result will usually justify the trouble. In all the examples shown the screen was the main factor in enabling a proper view to be secured. In film photography the screen cannot assist much, and the work is therefore haphazard.



1. Shewing upper and lower teeth of right jaws.

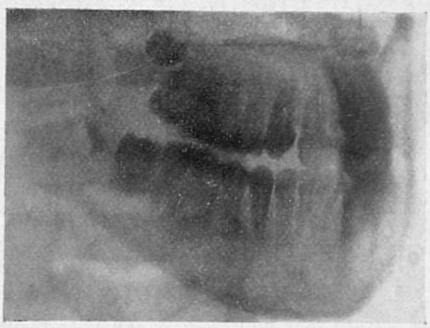
9. Three molars in upper jaw dead and shewing periodontitis.

10. Periodontitis, upper teeth.

jaw immediately above the two lower stopped
fragment of root is seen lying in a clear space
s cavity. This was the cause of a sinus on the
eek discovered by X-ray examination.

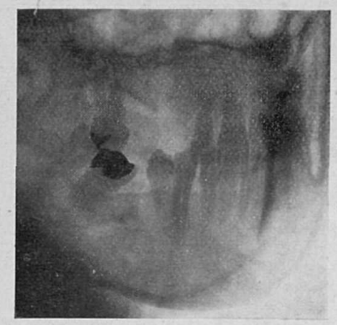
5. Upper jaws. Two molars and one premc
ing signs of old periodontitis. The nerve c
occluded.

l teeth in upper jaw. Clear area above
ctive inflammatory condition in bone.



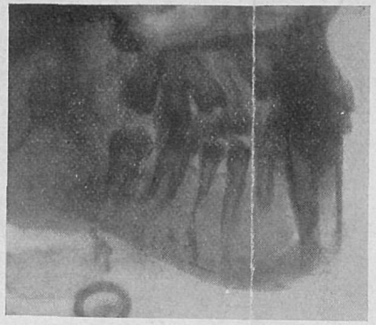
14. Shews upper and lower jaws right side from
wisdom to central incisor.

y.

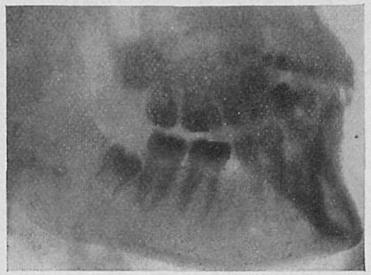


1. Shewing upper and lower teeth of right jaws.

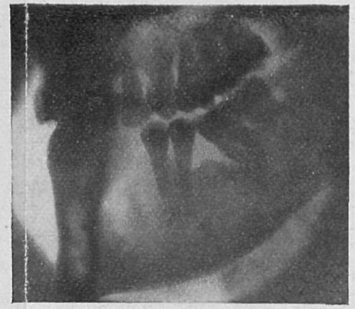
2. Unerupted canine lying obliquely above temporary tooth.



3. Healthy, but misplaced teeth. Two unerupted in upper jaw.



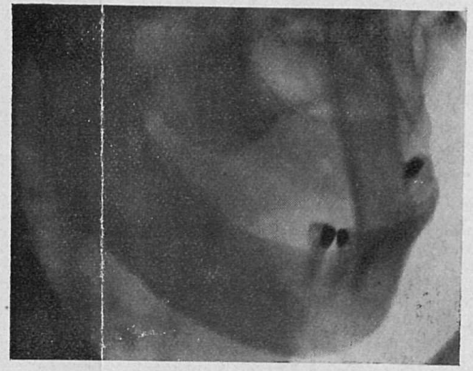
8. Several unerupted teeth shewing apparent confusion.



9. Three molars in upper jaw dead and shewing periodontitis.

10. Periodontitis, upper teeth.

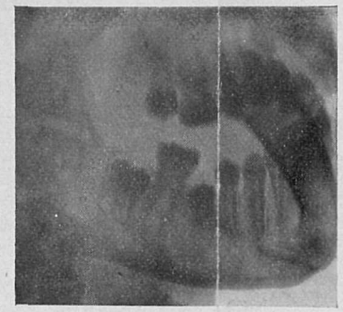
4. Behind the single molar in lower jaw a large piece of detached alveolus may be seen. This was the cause of a chronic sinus. Upon removal two partially absorbed roots were discovered embedded in the fragment.



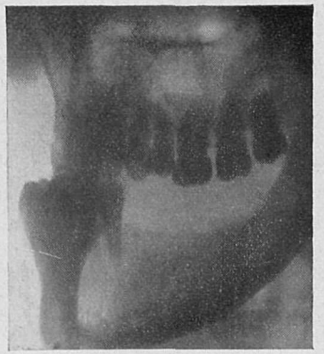
11. In upper jaw immediately above the two lower stopped teeth a tiny fragment of root is seen lying in a clear space over abscess cavity. This was the cause of a sinus on the cheek discovered by X-ray examination.

5. Upper jaws. Two molars and one premolar shewing signs of old periodontitis. The nerve canals are occluded.

6. Molar regions upper and lower healthy teeth. Wisdoms unerupted. Note the clear pulp cavities and nerve canals which are traceable through the apices.

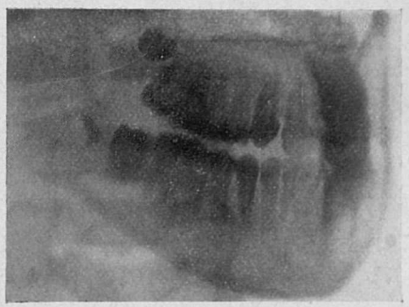


7. Six year old molar crowded by the two adjacent teeth.



12. Typical old periodontitis around upper molars. Note the disappearance of pulp cavities and the extreme density of the teeth.

13. Old dead teeth in upper jaw. Clear area above represents active inflammatory condition in bone.



14. Shews upper and lower jaws right side from wisdom to central incisor.

Skiagrams illustrating the Plate in Dental Radiography.

Enlargements of the Spleen.

CLINICAL LECTURE BY HERBERT FRENCH.

SYNOPSIS OF LECTURE.

Case shown—Pseudoleukæmia infantum in a child of 6 months. Great enlargement of the spleen, moderate of liver, marked anæmia, wasting.

Physical signs of enlarged spleen—Palpation more valuable than inspection, percussion, or auscultation. Details given. If dislocated, diagnosis may be very difficult, sometimes simulated. Most spleens are clearly recognisable as such on careful examination; but sometimes it may be *resembled by certain other tumours*, especially by: Left lobe of liver; left hydronephrosis; left pyonephrosis; left renal new growth; left suprarenal tumour; fæces in colon; growth in colon; growth in stomach; contracted tuberculous omentum; pancreatic cyst (or cyst of lesser omental sac). First five much more likely than the remainder. For kidney tumours, besides urine changes, possibly variabilities in size of tumour and amounts of urine; cystoscopy; pay special attention to mobility on respiration, to filling up of left loin, to non-crossing of middle line, and to getting hand between tumour and rib margin. Hypernephroma most nearly resembles spleen; fortunately very rare. May be suggested by premature pubic hair in girls, obesity in boys.

Minor enlargements of spleen not discussed.

Major enlargement of spleen has following chief causes:—

1. Splenomedullary leukæmia.
2. Lymphatic leukæmia.
3. Pernicious anæmia (spleen generally but little enlarged).
4. Splenomegalic polycythæmia (Vaquez's disease).
5. Hodgkin's disease.
6. Splenic anæmia.
7. Splenomegalic cirrhosis.
8. Fungating endocarditis.
9. Pseudoleukæmia infantum: von Jaksch's disease.
10. Tropical fevers: malaria: Kala Azar.

Splenomedullary leukæmia—Huge spleen. No big glands. Leucocytes 200,000 to 1,000,000. Myelocytes abundant.

Lymphatic leukæmia—Moderate spleen. Big glands. Leucocytes 80,000 to 500,000. Lymphocytes (small or large) upwards of 95 per cent.

Mixed leukæmia combines characters of above two.

Pernicious anæmia—Spleen seldom very big. Characteristic primrose yellow tint of skin. Pronounced anæmia, high colour index, megalocytes. No characteristic leucocyte changes. N.B.—Remember poikilocytosis, great variations in size, presence of nucleated forms and polychromasia, may occur in *any* anæmia if it is severe enough.

Vaquez's disease—Adults. Main features, weakness, dyspnœa, cyanosis, big spleen and red cells may be 7 million to 10 million. Leucocytes not altered much.

Hodgkin's disease—Big spleen, big glands, no leucocytosis. Relations to lymphadenoma and to lymphosarcoma.

Infective endocarditis—A cardiac case with pyrexia, changing bruits, anæmia, infarcts. N.B.—Remember no big spleen in simple heart failure, so that a big spleen in a heart case is always suggestive of infective endocarditis.

Cirrhosis of liver—The form which has the biggest spleen is generally in young persons, and often in several members of same family. Illustrations. Chubbed fingers. Leucocytosis indicates bad prognosis.

Splenic anæmia—Very often undiagnosed cirrhosis: =Banti's disease. Blood changes negative.

Pseudoleukæmia infantum—Case shown. Relations to congenital syphilis. Value of excising spleen.

GENTLEMEN,—The subject for discussion to-day is splenic enlargement, and we have here a case from Clinical in which enlargement of the spleen associated with considerable anæmia are the two most prominent symptoms. The patient is a girl infant six months old, very undersized, as you see, though at birth she was a full-term child weighing 9 lbs., and she was breast-fed until the time of her admission to the hospital. The report of the case has been written by Dr. Seabrooke, and continued by Dr. Ryle. There is no history of specific disease in the family, the mother has had no miscarriages, and there are three other children, aged 7, 5, and 3 years respectively, all quite well. About three months ago the patient's skin began to change to a decided yellow, blue rings appeared round the eyes, a slight cough developed, there was a steady loss of weight, and at the same time the abdomen became more prominent. The bowels have been quite regular. The temperature on admission was normal, the respiration rate 60 per minute, and the pulse 172 per minute; the weight of the child was then 6 lb. 10½ oz. There were no abnormal physical signs in the heart or lungs. The prominence of the abdomen was found to be due to moderate enlargement of the liver, which came one and a half inches below the right costal margin, and to great enlargement of the spleen, which projected down to the level of the crest of the ilium. Dr. Ryle has very kindly mapped out both the spleen and the liver with ink upon the skin, so that even those of you who are furthest from me can easily see how big these two organs are. The patient's blood was examined, the red corpuscles numbering 2,335,000 per cubic mm., the hæmoglobin measuring 33 per cent. of normal, the colour index being, therefore, 0·64; the leucocytes numbered 13,000 per cubic mm. and the differential leucocyte count showed 60 per cent. of large lymphocytes, 20 per cent. of polymorphonuclear cells, 3 per cent. coarsely granular

eosinophile cells, 11 per cent. of small lymphocytes, and 6 per cent. of myelocytes. Stained blood films showed large numbers of nucleated red corpuscles, whilst poikilocytosis was also pronounced. The child was given ¼ minim of liquor arsenicalis three times a day to begin with, and this was subsequently increased to ½ minim and then to ¾ minim three times a day, but diarrhœa soon set in, even with this small dose of the remedy, and it had to be discontinued.

PHYSICAL SIGNS OF SPLENIC ENLARGEMENTS.

The first point that you will ask is, how do we know that the mass marked out upon this child's abdomen is an enlarged spleen? We know this, first, because in the present case the tumour gives practically all the physical signs generally associated with a big spleen; and, secondly, because it does not give the physical signs which are generally associated with other masses which may simulate an enlarged spleen. What, then, are the physical signs of a splenic enlargement?

As in the case of other organs, these may be subdivided under the usual headings of Inspection, Palpation, Percussion, and Auscultation; but as a matter of fact neither inspection nor auscultation is of much value in connection with the spleen, the chief diagnostic physical signs being those dependent upon palpation and percussion respectively, and particularly upon palpation. It is the hand which tells one, as a rule, that a given tumour in the abdomen is the spleen. On inspection one sees, of course, that the abdomen is enlarged, and, as in the present instance, one may often notice that the swelling is asymmetrical, the upper left part of the abdomen being more bulged than the rest. In very thin subjects the eye may be able to make out the notched border of the organ beneath the skin, and when the patient breathes steadily and deeply one may see that the mass moves up and down with respiration, and that it comes out from under the left costal margin close under the ribs. However, whether one notices these things with the eye or not, careful palpation with the hand will often by itself suffice to tell one that one is dealing with a big spleen. The mass comes down from beneath the left costal margin so close to the ribs that one cannot, as a rule, get the edge of one's hand between them and the upper pole of the tumour as one can in the case of most renal tumours; the mass feels to be close behind the skin of the abdominal wall, and if it is felt bimanually—that is to say, with one hand in the patient's loin and the other laid flat upon the front of the abdomen—it is felt more easily by the anterior than by the posterior hand, because it does not fill out the loin as a kidney does unless the mass is quite enormous. The anterior border of the tumour is generally well defined, and as one passes one's fingers along it one feels one, two, or more characteristic notches, for a big spleen generally is precisely the shape of a normal spleen, but upon a magnified scale. Whereas the upper pole cannot be felt because the hand cannot get between the left costal margin and the tumour, the lower pole is generally well defined, and as one palpates it and asks the patient to take a deep breath, one can feel the big spleen moving up and down with respiration, except in those cases in which the tumour is so large that the lower pole is jambed tight against the bones of the pelvis, so that it cannot move down at all.

The outer and posterior surface of a splenic tumour is generally smooth and rounded, and so is its lower pole in marked contrast with the thinner and notched anterior border. Generally the organ is painless, but if there is perisplenitis, or if there has been a recent infarct in the spleen, there is not only superficial tenderness of the abdomen, but also palpation causes the patient acute pain. The direction taken by the lower pole of the organ as any progressive enlargement takes place is also characteristic; instead of coming vertically downwards from beneath the ribs, and thus being confined mainly to the left side, the lower pole generally advances along a curve, so that it crosses the middle line of the abdomen just below the umbilicus, unless there is something, such as a big liver or some other abdominal mass to prevent this. In splenomedullary leukæmia, in which the enlargement generally attains the greatest size we see, the lower pole of the spleen may be in the right iliac-fossa, the only part of the abdomen not containing spleen then being the right upper quadrant. On percussion the tumour is dull in front, for it very rarely happens that any coil of intestine lies between it and the abdominal wall, as in the case of the descending colon and the left kidney; there will be resonance over that part of the front of the abdomen which does not contain the enlarged spleen, unless there is ascites or something else of a similar nature to complicate the case, and not infrequently, if one percusses across the dull spleen outwards into the left flank, one may detect some resonance in the loin behind it, if the descending colon is distended with air.

Auscultation of the spleen seldom assists the diagnosis, but it is worthy of note that one may occasionally hear a blowing systolic bruit over it synchronous with the heart beats, and when there is perisplenitis, a peritonitic rub can be heard sometimes when the patient moves the spleen up and down by taking deep breaths.

THE DIAGNOSIS OF ENLARGED SPLEEN FROM OTHER TUMOURS.

In nine cases out of ten physical examination by itself suffices to determine that the abdominal mass is an enlarged spleen, but in exceptional cases the physical signs are sufficiently abnormal to render the diagnosis doubtful. The two chief conditions under which difficulties of this kind arise are, first, when there is at the same time great enlargement of the liver so that the spleen cannot take its usual course downwards and to the right, when it may be difficult to tell whether one is palpating an organ separate from the liver as distinct from an irregular enlargement of the left lobe of the liver; and secondly, when the spleen has become bodily displaced by stretching of its ligaments or from some other cause, so that instead of coming down from close beneath the left costal margin, as it nearly always does, it lies altogether lower in the abdomen, and one can feel its upper pole as well as its lower; one has known such spleens to have been displaced even down into the pelvis, so as to simulate an ovarian cyst or something of that kind; unless there are positive blood changes, or unless one can feel the characteristic notches in the displaced organ, it is very difficult indeed to be sure that it is a spleen unless it is demonstrated to be so by laparotomy.

Sometimes, however, even when the spleen is enlarged but otherwise still occupies its normal position, it is not quite easy to differentiate it from certain other intra-abdominal masses, of which one may discuss in particular—

1. A left renal tumour.
2. A left suprarenal tumour.
3. A cyst of the lesser omental sac.
4. A tumour of the stomach.
5. A tumour of the splenic flexure of the colon or of the descending colon.
6. A tuberculous mass in the rolled and curled up omentum.

I might also mention rarer conditions such as hydatid cysts of the left lobe of the liver, but these are so very exceptional that I would rather confine myself now to more common conditions.

In all cases of doubt a complete blood examination will probably be required in the first instance, in order to exclude the possibility of those four diseases in which the spleen is, or may be, enlarged and the blood picture is pathognomonic—namely, spleno-medullary leukæmia, lymphatic leukæmia, pernicious anæmia, and spleno-megalic polycythæmia. If, however, the results of the blood examination are negative, this does not exclude the possibility of the mass being an enlarged spleen, and therefore careful consideration has to be given to all the various symptoms and physical signs that may be presented by the patient. In the case of a left renal tumour sufficiently large to suggest the possibility of a big spleen as an alternative, the cause of the renal disease will almost certainly be one or other of three things—namely, hydronephrosis, pyonephrosis, or a malignant new growth. Careful, and if necessary repeated, examinations of the urine will be made, and the likelihood of the trouble being in the kidney rather than in the spleen will be suggested by the presence, intermittently or permanently, of pyuria, especially if renal tube casts are found at the same time, or hæmaturia, though it must not be forgotten that both these, and especially hæmaturia, may be associated with some of the diseases that also cause enlargement of the spleen. If there is merely albuminuria without pyuria or hæmaturia, and without abnormal microscopical constituents of the urine, the differential diagnosis is helped very little indeed, for many of the causes of splenic enlargement may also give rise to some albuminuria.

A very important point is to have the total amount of urine passed in each twenty-four hours measured accurately, precautions being taken not to have any urine lost at the time of defæcation by getting the patient to pass his urine before he goes to stool. If there are wide fluctuations in the amount of urine passed—such, for instance, as twenty or thirty ounces on each of three or four consecutive days, and then, as it were, a flood of seventy or eighty ounces upon the next day following, and if this phenomenon recurs, it is very likely that there is an intermittent blocking of the flow from the renal pelvis, and a diagnosis of hydronephrosis is suggested if there is no pus in the urine, or pyonephrosis if there are pus cells on those days when large quantities escape. If, at the same time, the size of the tumour is found to

vary, becoming larger on those days when the least urine is passed and smaller when the urine is abundant, the diagnosis of hydronephrosis or pyonephrosis is established with considerable certainty.

In the case of a large new growth of the kidney, there may be positive urinary changes, especially hæmaturia; but on the other hand there may be, for days and weeks at a time, no abnormal urinary constituents, and unless operation is resorted to to establish the diagnosis, beyond doubt one may have to rely solely upon the physical signs in differentiating the large kidney from a possible enlargement of the spleen. The renal tumour nearly always retains, more or less, the ordinary kidney shape, so that it practically never presents a comparatively thin, and especially not a notched internal border; the hylum may be made out as a depression in the mass, but this feels very different, as a rule, to the notches of a spleen. The surface is generally smooth, though there may be one or more subsidiary rounded projections if there are cysts in the organ, or more nodules of growth than one. Such a nodular outline of the surface is presented, very seldom indeed, by a spleen.

One can nearly always get the flat part of one's hand between the left renal tumour and the left costal margin, even if one cannot palpate the upper pole of the organ; the mass may move to some extent with respiration, but generally to a much less extent than does a spleen, and it very seldom crosses the middle line however big the tumour gets. Most important of all the physical signs, however, which differentiate a renal from a splenic tumour, is the fact that a kidney, in nine cases out of ten, fills out the corresponding loin so that on bimanual palpation the posterior hand feels it even more readily than does the anterior, and the mass can be pushed forward from the loin towards the anterior hand in a way which at once serves to exclude splenic enlargement. If the patient sits up in bed with his head bent forwards towards his knees, and one then looks down his back in the middle line, one can very often observe with the eye the fact that the loin on the affected side is less hollow than the other, and sometimes whereas on the sound side the loin is slightly concave, on the affected side it may be actually convex. It is generally stated that percussion also helps to differentiate a renal from a splenic tumour, in that whereas there may be some slight resonance in the loin behind a splenic tumour, in the case of a renal tumour, whilst the loin is always dull, there is sometimes sufficient air in the colon passing down the front of a renal tumour to cause a band of resonance here, which is practically never present in the case of a splenic tumour.

In practice, however, percussion seldom assists much, for it quite often happens that the front of a big renal tumour is entirely dull, notwithstanding the descending colon in front of it, whilst the loin is quite often not resonant in the case of a splenic tumour, because the descending colon is so often empty, even of air. One might, perhaps, make use of percussion as a helpful physical sign more often in these cases, if one were to inject air into the colon with a suitable pump or syringe, so as to distend the descending colon with gas. This, however, will only be necessary in quite exceptional cases. One may add, perhaps, that not infrequently one has actually felt the descending colon kind of crackling under one's fingers, when one was palpating the front of a renal tumour, and this is practically never the case with a splenic tumour.

One must not forget the value of examining the bladder with the cystoscope in many of these cases, for one may thereby demonstrate that there is either no urine at all coming from the left ureter or a fluid of a different kind from that which comes from the right.

The differentiation between a suprarenal tumour and a splenic tumour may be very difficult indeed, for there will be no urinary changes to help one as may be the case with an enlarged kidney, and there are often no symptoms or blood changes characteristic of either suprarenal or of splenic disease in the case. The physical signs of a greatly enlarged suprarenal—and one may mention that occasionally these masses are bigger than cocoanuts—are very similar to those of a renal enlargement, but the mass is situated rather higher in the abdomen and in contact with the diaphragm, so that the tumour may move with respiration as freely as the spleen does; one may be able to feel its upper pole and one may often be unable to get one's hand between the suprarenal tumour and the costal margin. Fortunately for the sake of diagnosis, left suprarenal tumours are very much rarer than are splenic tumours, so that one is not confronted with the difficulty frequently. It may interest you to know here of one particular disease in which, whether the physical signs simulate splenic enlargement or not the diagnosis of suprarenal tumour is quite

easy, though the cases are rare, and that is the so-called hypernephroma of children, characterised not only by the presence of the abdominal tumour, but also by the premature development of pubic hair, and of the external genital organs; a case of this kind was recently in Clinical, and it is recorded in the last volume of the Guy's Hospital Reports, from which I show you the accompanying pictures, which will help you to remember the disease.

Although the child was only $6\frac{1}{2}$ years old, you will see that she had as much pubic hair as a girl of 20, and this she had had since she was 18 months old, whilst at the same time the clitoris is greatly hypertrophied out of all proportion to the rest of the child's development, which was natural. There is another type of metabolic change met with in association with hypernephroma, and that is more common in boys, namely, a tremendous overgrowth of the subcutaneous tissues, generally so much so that one has an apparent infant Hercules before one, or a Peckham fat boy.

Cysts of the lesser omental sac have also been labelled pancreatic cysts sometimes because the fluid in them ultimately contains, as a rule, the various pancreatic ferments which have escaped into it from the pancreas which has become stretched over the surface of the cyst. They are much rarer than enlarged spleens, and seldom really simulate them, for the cysts lie, as a rule, in the middle line, or just to the left of the middle line, and one can generally get one's hand easily between them and the costal margin. In difficult cases, however, the diagnosis can sometimes be determined only by laparotomy.

A gastric tumour, especially that rare disease sarcoma of the stomach, has sometimes simulated an enlarged spleen. As a rule, however, the mass is far less smooth than is a spleen, one can generally move it about sufficiently to get one's hand between it and the costal margin, and the patient will have had more or less definite gastric symptoms, especially pain in relationship to food and vomiting, with or without hæmatemesis to help the diagnosis.

A malignant mass or even a large accumulation of fæces in the left half of the transverse colon or in the upper part of the descending colon has more than once simulated enlargement of the spleen at a first examination. In the case of accumulated fæces, however, one can generally alter the shape of the mass on palpation much as one can mould a stiff mass of putty, and one can never do this with a spleen; whilst, when there is a carcinoma, if the diagnosis is not clear at the first examination, the progress of the case will generally serve to distinguish the two in a short time, even if there are no direct bowel symptoms, such as the passage of blood and mucus per rectum, recent and increasing constipation, pain along the transverse colon, or signs of increasing obstruction to the bowel. In cases of doubt, the use of the X-rays at intervals after the administration of a bismuth meal may show definitely that the lesion is in the colon.

In regard to tuberculous masses in the abdomen, and particularly in the omentum, all kinds of difficulties of diagnosis arise. Such an omentum may simulate an enlarged liver, or, more rarely, an enlarged spleen. As a rule, however, even when the mass is mainly beneath the left hypochondrium one can make out that its surface is not smooth, but variously crinkled and nodulated, and it is seldom so thick as not to transmit a certain amount of bowel resonance through it, so that on percussion it is less dull than a corresponding splenic tumour would be. The patient is generally a child, and there are very often other masses to be felt elsewhere in the abdomen, where glands have become enlarged and either caseous or cretaceous. One mentions the condition here less, perhaps, because it may simulate an enlarged spleen in particular than because an old tuberculous omental mass has often led to practically every kind of difficulty in the differential diagnosis of intra-abdominal conditions.

(To be concluded.)

Papers by Guy's Men.

A. S. Blundell-Bankart, M.C., F.R.C.S. (with another): A case of Spinal Tumour with Scoliosis: Operation.—*Lancet*, 21st June, 1913.

Kenelm H. Digby, M.B., B.S., F.R.C.S.: The Ingestion of Bacteria by the Subepithelial Lymphatic Glands in Health.—*Ibid.*

J. M. Fortescue Brickdale, M.A., M.D. Oxon.: Methods of Diagnosis in Gastric Cancer.—*Borstal Med. Chir. Journal*, June.

PAPERS RECEIVED.—Nursing Times, The Hospital, Clinical Journal, New York State Journal of Medicine, St. Mary's Hospital Gazette, London Hospital Gazette, St. Thomas's Hospital Gazette, Magazine of the Royal Free Hospital, University College Hospital Magazine.

A few Cases illustrating the importance of a Complete Examination of the Expectoration.

BY J. A. B. HAMMOND, M.B.

A RECENT writer in your pages deplored the amount of clinical material allowed to run to waste by the general practitioner. Speaking for myself, as a G. P., it is not so much a matter of indifference as a natural diffidence in sending any account of one's limited experience to a Hospital Gazette, where there is such a wealth of material on the spot upon which to draw. However, I hope the following brief notes may be of some interest to a fellow G. P., and encourage others to follow suit.

There is no need for me to emphasize the increasing importance of arriving at an exact diagnosis of the infecting organism in disease, since the introduction of therapeutic inoculation. When we were content to treat cases on general lines, it was often merely a matter of academic interest to know exactly the micro-organism causing the trouble, but now it is frequently of practical importance that we should confirm and supplement our clinical diagnosis by one based on a bacteriological examination.

Until two years ago I was for the most part content, when having expectoration examined, to ask whether the tubercle bacillus was present or not, and leave it at that. A positive result I regarded as final—whilst a negative result left one *in statu quo*. Recent experience has led me, as a routine practice, to have a complete examination made for all the organisms present. The extra cost is a small matter, and the information gained is often of the greatest help.

The first case was that of a man, 35 years old, who was invalided home from India with a persistent cough, profuse expectoration, and scattered catarrhal signs over the lungs, chiefly marked at the left apex. His expectoration had been examined twice for tubercle bacilli, with negative results. Before coming to Shanklin, treatment on general lines had been tried for three or four months with little or no benefit. I had a complete examination of the expectoration made, again tubercle bacilli were not detected, but inoculated media gave an almost pure culture of pneumococci. From this a personal vaccine was prepared, and after seven injections the symptoms and signs had completely cleared away. In passing, I might point out that I have generally found the graduated doses, as sent out by the Clinical Research, to be too rapid in their scale of increase, and that unless one modifies the dose for oneself (which is, of course, an easy matter), the reaction may be rather violent.

The second case is that of a lady, who some years ago came to me labelled as suffering from phthisis. Considering her symptoms were persistent cough, some expectoration, loss of weight, general ill-health, coupled with catarrhal signs limited to the left apex, I did not hesitate to accept the diagnosis, although tubercle bacilli had not been found despite repeated examination. After an interval of four years this lady, on returning to the Island, came to see me with regard to the advisability of undergoing tuberculin treatment, for, although her general health was better, the physical signs remained, and during the past winter her cough had given trouble. Before answering her question I had the expectoration fully examined; again tubercle bacilli were not found but inoculated media showed large numbers of streptococcus longus, some pneumococci, and many micrococci catarrhalis. Here, then, was a case for which, on clinical grounds alone, one might very well have recommended tuberculin treatment, although the bacteriological examinations very clearly pointed to its not being tubercular at all.

I have often wondered whether some of our failures, when using tuberculin in pulmonary cases—as compared with its success in surgical tuberculosis—may not have been due to paying insufficient attention to the mixed character of the infection we are treating. I left Guy's with the impression that pulmonary cases with a mixed infection always ran an acute and toxic course, but I have since been surprised to find many with a most heterogeneous collection of organisms in their expectoration running quite a mild course. In connection with mixed infections, it will be most interesting to watch what success Dr. A. F. Schafer's treatment with phylacogens has in England. A few weeks ago a business man from the north consulted me casually about a troublesome cough, associated with loss of weight and general ill-health. His physical signs, which were limited to the left apex, were marked dulness, diminished air-entry and voice sounds, with numerous râles. Although his expectoration had been tested no less than *nine* times for tubercle bacillus, with negative results each time, I was informed that he was still regarded as probably tubercular by one specialist he had seen.

It seemed to me that the obvious advice to give was, that since his expectoration had been examined nine times to find what was not there, he should have it done a tenth time to find what was there, and if suitable to get a vaccine prepared. On his return home this was done, and numerous pneumococci found, from which a vaccine was prepared. After working up to an injection of 100 million, the patient writes me: "To-day I am better than I have been for months, and have been going to busines each day (he had been away from work for some nine months before). An examination of my expectoration shows a considerable reduction in the number of cocci present." We have rightly been taught to be very cautious about accepting negative evidence, and to demand repeated examinations before we decide that the tubercle bacillus is not responsible for our patient's condition, but such cases as the last two, and the results just published by Drs. Sutherland and Jubb, of their examination of school children, showing that

many cases of "phthisis" or "suspected phthisis" are really chronic pneumococcal infections, would suggest that we have been too exacting and too ready to diagnose phthisis on clinical grounds, when a more complete bacteriological examination would give us the key to the situation.

The remaining two cases I have to mention were both chronic lung conditions with cavitation, one tubercular, and the other said to be the result of influenzal pneumonia. These patients developed a troublesome multiple arthritis, which did not yield to ordinary treatment. Thinking it might be the result of a chronic septic absorption, I had the expectoration thoroughly examined; streptococci were found associated with the pneumococcus and micrococci of the catarrhalis type. Mixed vaccines were prepared and given, with the gratifying result that one patient was completely relieved of her arthritis and has remained so, whilst the other was considerably better until she fell a victim to a very acute attack of influenza, which was epidemic at the time, and the treatment had to be stopped.

Correspondence.

To the Editor of Guy's Hospital Gazette.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—Ed., G.H.G.]

The Chapel Choir,

Dear Sir,—Many of us look back at our School or College life with regret for the good time that is past, and perhaps to the Chapel services—the voluntary ones—remembering how hearty they were, and the enjoyment our favourite hymns gave us. We can now realize how the corporate worship brought out the corporateness of our lives. The lack of the sense of corporateness is one of the great drawbacks to a non-residential University such as the University of London, of which Guy's Medical School and Guy's Chapel are a part. May I, therefore, through your columns, draw the attention of Guy's men to our Chapel and the services, particulars of which are posted weekly in the colonnade, and also to our men's choir. At present the musical part of our services is mainly sustained by the nursing staff of the Hospital, and splendidly they do it, but we lack the foundation which male voices alone can supply. Our Choir Secretary, Mr. Evelyn Scott, will be pleased to give any information.—Yours faithfully,

A. E. POPHAM, Acting Chaplain.

Guy's Calendar for 1914.

Dear Sir,—May I ask you to be kind enough to mak known, through your valuable Journal, the scheme for a Calendar which I am organising. It is in aid of the Endowment Fund for a Cot, by which the Ladies' Association hopes to celebrate its 20th Anniversary, and to form a permanent memorial of the early years of its work. Each subscriber is asked to send one quotation, motto, or proverb, and 2s. The quotations will be made into a Calendar for 1914, with the names of the contributors attached to their selections. The scheme has had the approval of the Governors and Staff, and a large number of quotations have already been obtained, but several hundred more are needed. If all those interested in the Hospital will help, and will endeavour to interest their friends the success of the scheme will be assured. Contributions may be sent to me or to any member of the Committee, viz: Mrs. Cosmo Bonsor, the Hon. Mrs. Henry Molyneux, Mrs. Lauriston Shaw, the Matron, and Miss Amos. A form for the purpose will be found as an inset in this issue. The Calendars will be sent to subscribers early in the autumn, and will form a very suitable Christmas souvenir for those interested in Guy's.—Yours faithfully,

E. M. MASON, Hon. Sec., Banstead and Sutton Branch, Guy's Hospital Ladies' Association.

"Home Croft,"
Orpington, Kent,
June 23rd, 1913.

Appointments.

The following appointments and re-appointments are announced:—

Hospital.

Obstetric Surgeon.—Mr. Harold Chapple.

Assistant Physician.—Dr. Hunt.

Surgeon to the Actinotherapeutic Department.—Dr. Iredell.

Anæsthetists to the Hospital.—Mr. Page, Dr. Shipway, Mr. Depree, Mr. Bromley, Mr. Gardiner, Mr. Todd, Mr. McNair.

Resident Surgical Officer.—Mr. J. G. Saner.

Chemical Pathologist.—Mr. Ryffel.

Morbid Histologist.—Dr. Nicholson.

Medical Registrars.—Mr. Poulton, Mr. Barber, Mr. Heaton.

Surgical Registrar.—Mr. Todd.

Obstetric Assistant.—Mr. McNair.

Ophthalmic Assistants.—Mr. Harry Lee, Dr. Maxted

Anæsthetist to Bright Ward.—Mr. Bromley.

Senior Assistant Bacteriologist.—Dr. Lucey.

Junior Assistant Bacteriologist.—Mr. Skene Keith.

Assistant Surgical Radiographer.—Mr. H. N. Eccles

Medical School.

Demonstrator of Operative Surgery.—Mr. Mullally.

Demonstrators of Anatomy.—Mr. Layton, Mr. Bromley.

Demonstrators of Physiology.—Dr. Kennaway, Mr. G. Marshall.

Demonstrator of Chemistry.—Mr. Merriman.

Demonstrator of Physics.—Mr. H. H. Abram.

Demonstrator of Biology.—Mr. T. Reed.

Dental School.

Demonstrators of Practical Dentistry with charge of Revision Classes.—Mr. Malleson, Mr. Doubleday.

Demonstrators of Practical Dentistry with charge of Probationary Classes.—Mr. Stranack, Mr. Hodgson.

Demonstrator of Practical Dentistry with charge of Extraction Classes.—Mr. E. A. Tomes.

Demonstrators of Prosthetic Dentistry.—Mr. Wotton, Mr. Pritchard.

Demonstrators of Dental Microscopy.—Mr. Dowsett, Dr. Kennaway.

Demonstrator of Orthodontics.—Mr. F. B. Bull.

Curator of Dental Museum.—Mr. Dowsett.

Dental Radiographer.—Mr. Achner.

Civil.

H. G. Biddle, M.R.C.S., L.R.C.P., Certifying Surgeon under the Workshops and Factories Act, for the Hoxne District of County of Suffolk.

R. A. Greeves, M.B., B.S., F.R.C.S., Surgeon to Eye Department, Paddington Green, Children's Hospital.

L. Price Harris, M.R.C.S., L.R.C.P., L.D.S., Dental Surgeon to Queen's Hospital for Children, Bethnal Green, with charge of L.C.C. cases.

Naval and Military.

Fleet-Surgeon P. M. May, R.N., to *Fisgard*.

Staff-Surgeon C. H. Dawe, R.N., to *Forward*, on commissioning.

Surgeon C. G. Sprague, R.N., to *Bulwark*.

Captain C. H. Denyer, R.A.M.C., has been appointed or duty at Landour.

Captain G. H. Rees, R.A.M.C., has been selected to attend the next course for promotion to rank of Major, at R.A.M. College.

Lieut.-Colonel G. T. Birdwood, I.M.S., has been appointed Professor of Obstetrics at King George's Medical College, Lucknow.

Lieutenant F. J. Kolapore, I.M.S., has been promoted Captain, with effect from 24th Oct., 1912.

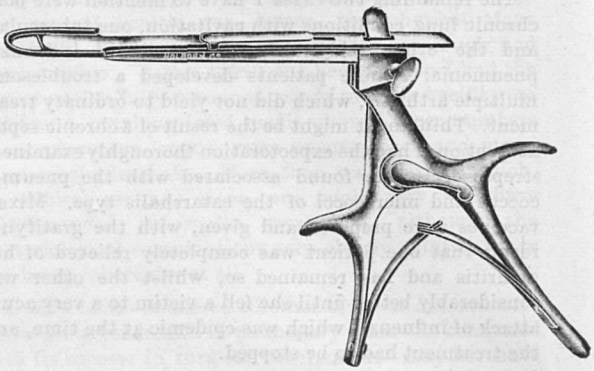
Territorial Force.

6th London Field Ambulance, R.A.M.C.—P. Seymour Price, to be Lieutenant, dated 2nd June, 1913.

Specialities.

Tonsillectome.

(Suggested by Mr. John F. O'Malley, F.R.C.S.)



This instrument, which is designed especially for enucleation of the tonsils is a modification of that designed by Ballenger of Chicago. Its essential features are:—

1. A thin ring (slightly more than $\frac{1}{16}$ inch on section). The outer or convex aspect of the ring is complete, as there is no slot.

2. On the inner aspect of the ring a shallow slot recess is left which, when the instrument is ready for use, is filled with lead.

3. The margin of the upper rim which surrounds the opening is square and not bevelled, as in the usual type of Tonsillotome.

4. The opening is small and square posteriorly. The size, which is of the most general use, gives the following measurements: (*a*) Transverse diameter $\frac{11}{16}$ inch. (*b*) Antero-posterior diameter $\frac{10}{16}$. A second size needed for a small percentage of cases, is $\frac{13}{16} \times \frac{13}{16}$ inch.

5. The shaft and blade are $6\frac{1}{2}$ inches long. The shaft is stout and strong, the blade is blunt.

6. The blade is driven home by a lever in the handle, and not by the thumb.

It is claimed for it that the thin ring not being bevelled enables one to thread it on any tonsil no matter how flat, with very little risk of slipping when the gland is being raised forwards to the anterior pillar of the fauces. The small opening fits tightly around the base of the tonsil when the latter is squeezed through it and the capsule is inverted in this manœuvre. The thin ring and small opening have the further combined advantage of keeping the size of the instrument such that it will fit any fauces and remove any type of tonsil in one bite (if the larger opening is used). The stout shaft is necessary to prevent bending when pressure is exerted in raising the tonsil forwards. The shaft being long, the handle

clears the patient's cheek and chin and facilitates movements. The dull-edged blade, entering between the anterior faucial pillar and the tonsil, strikes the anterior border of the capsule, and the leaded slot of the ring rests against the posterior border.

The makers are the Holborn Surgical Instrument Co., Ltd., 26, Thavies Inn, E.C.

The Milward Fund.

FIFTH LIST OF SUBSCRIPTIONS FROM GUY'S MEN.

	£	s.	d.
Amounts already acknowledged	162	15	6
Wilson Tyson, Lowestoft	1	1	0
Hugh Bennett, Builth	1	1	0
Bernard B. Gough, Bristol	1	1	0

Particulars of the Fund can be seen in the GAZETTE of May 10th.

Further Donations will be gratefully received by the Hon. Treasurer, Mr. William Sheen, 2, St. Andrew's Crescent, Cardiff.

Nursing News.

THE tennis match between Guy's and the Northern Hospital, reported in our last issue, was one of games in the First Round of the *Nursing Times* Challenge Cup. We regret that we did not make this clear last week as our contemporary not only gives the cup but arranges the whole competition.

United Hospitals Athletic Sports.

THESE sports were held at Stamford Bridge, on Tuesday, 24th June. There was a very poor attendance. Guy's had out a very fair team, and its prospects of winning the Shield were certainly better than last year. Matters were rather complicated, as Charing Cross Hospital sent in several competitors, though the Hospital was not competing for the Shield.

In the 100 yards Evans was placed second to Stewart of the London, who won in the record time of 10 secs.

In the half-mile Bowes, our first string, was just beaten for second place by Peterson of Bart.'s, Dawson of Thomas's being first.

The shot produced a close finish, the Charing Cross man—Sutton—winning, with Read of London second, our man Stokes being ¼ inch behind Read.

In the three-miles Barrow-Clough, Saw, and Coutts-Williamson, were left in at two miles with Shepherd of Charing Cross. Coutts-Williamson gave up one lap later, and after a hard finish Barrow-Clough came second, with Saw third.

We were unplaced in the hurdles and hammer, but Curle was only just beaten by Doorly (St. Thomas's) for first place in the high-jump. The latter won with 5ft. 3½ins., less than Curle cleared at our own sports.

In the long jump, Doorly again won with the poor jump of 19ft. ¼in., Medlock being second, ¾in. behind. The winning jump was less than either our first and second string did at our own sports.

Evans provided us with another second place in the 220 yards, being beaten by Stewart. We were unplaced in the mile, and in the quarter mile Bowes could only get up to second place, beating Curle by a couple of yards. The winner, Peterson of Bart.'s, ran a fine race.

The Shield went to London with 52; Thomas's being second with 40; Guy's third with 38. It was disappointing in that we should have won had our repsesentatives reproduced the performances of our own sports in the field events. We were very pleased to see the keenness with which all the men trained, especially the new ones, Curle, McAlpine, and Coutts-Williamson.

Golf.

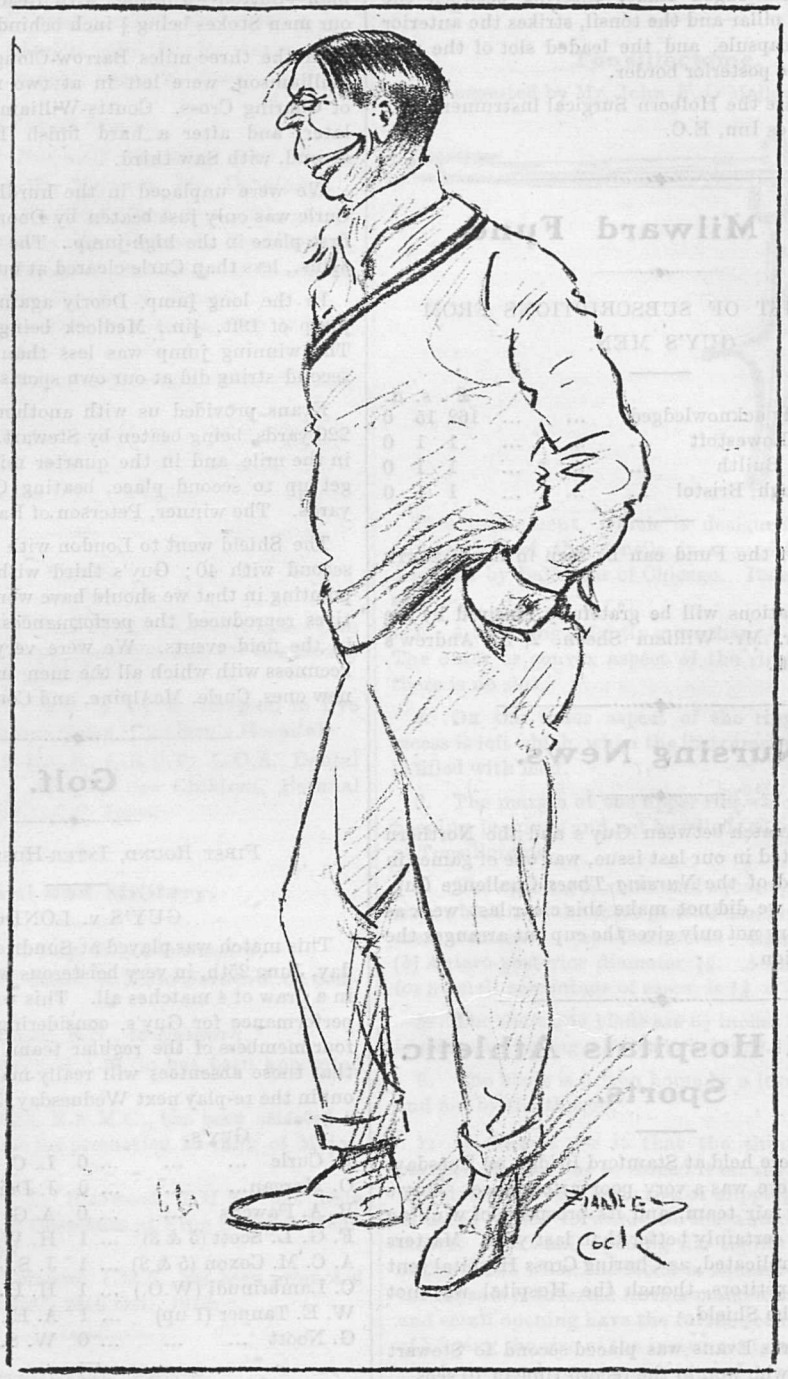
FIRST ROUND, INTER-HOSPITAL CUP.

GUY'S v. LONDON.

This match was played at Sundridge Park on Wednesday, June 25th, in very boisterous weather, and resulted in a draw of 4 matches all. This was quite a creditable performance for Guy's, considering they were without four members of the regular team, and it is to be hoped that those absentees will really make an effort to turn out in the re-play next Wednesday, July 2nd. Scores:—

GUY'S.		LONDON.	
R. Curle	0	L. C. Somervell (7 & 5)	1
O. Morgan...	0	J. Deignton (2 & 1) ...	1
R. A. Fawcus	0	A. G. Hardwicke (2 up)	1
F. G. L. Scott (5 & 3) ...	1	H. Whyte	0
A. C. M. Coxon (5 & 3) ...	1	J. S. Jolson	0
C. Lambrinudi (W.O.) ...	1	H. H. Matthias ...	0
W. E. Tanner (1 up) ...	1	A. E. Herman	0
G. Noott	0	W. S. Herman (3 & 2)...	1
	4		4

As we go to press we learn with great pleasure that Guy's beat London in the replay—5 games to 4.



"HARKY,"

OUR CRICKET CAPTAIN.

Swimming Sports.

Held in the Southwark Baths on Thursday, June 26th, 1913. The Entertainment was a very successful affair, and reflects great credit on the energetic Secretary, Mr. H. N. Eccles, and those who worked with him. All the events were contested with great keenness, and the attendance was very good indeed considering all things, although, perhaps, not quite up to last year's numbers. During the evening, Messrs. R. L. Ede, G. Masters, W. G. Reid, and R. Errington, of the Amateur Diving Association, gave a magnificent display of Diving which was greatly appreciated. Diving is to these gentlemen apparently as easy as falling off a log, and far more graceful. Their concluding effort, a Flight of Three Swallows Dive, was truly marvellous. Sir Alfred Fripp thanked them in the name of the Club at the end of the display, and they were heartily cheered. As in previous years, the Nurses' Race was eagerly watched, and, as far as we could judge, the betting was very free. A new feature was a Nurses' Diving Competition. This produced a keen contest in spite of the fact that several of the competitors looked rather nervous on the spring-board.

1. *Sixty-six Yards Scratch.*—J. York Moore, 1; C. H. Laver, 2; C. G. Coombes, 3. Time, 44⅘ secs. This is York Moore's fifth consecutive victory in this event.

2. *Sixty-six Yards Handicap for Nurses.*—Heat 1. Nurse Tyler-Cove (10 secs.), 1; Nurse Rees (scratch), 2. Heat 2. Nurse Loughman (7 secs.), 1; Nurse Boys (10 secs.), 2. Final. Nurse Loughman, 1; Nurse Tyler-Cove, 2.

3. *220 Yards Scratch.*—E. F. Llarena, 1; H. James, 2; E. S. Phillips, 3. Time, 3 min. 8 secs.

4. *Cork Competition.*—H. Hopson.

5. *Nurses' Diving Competition.*—Nurse Loughman, 1; Nurse Leggoe, 2; Nurse Sadlier, 3.

6. *Sixty-six Yards Handicap.*—R. Cade (15 secs.), 1; B. Laver (10 secs.), 2.

7. *Plunging.*—C. E. Reckitt, 47ft. 2in., 1; J. N. Martin, 39ft. 9in., 2.

8. *Balloon Race.*—A. Guinness, 1; J. N. Martin, 2.

9. *Neat Diving.*—C. L. Curle, 1; H. James, 2; E. F. Llarena, 3.

10. *Sixty-six Yards Breast Stroke.*—A. Guinness, 1; J. N. Martin, 2.

11. *Team Race: Medicals v. Dentals* (Holders).—This event resulted in a victory for the Medicals. Teams:—

MEDICALS.—J. York Moore, C. G. Coombes. E. G. Phillips, A. Anthony.

DENTALS.—E. F. Llarena, C. H. Laver, Mac. B. Allan, C. L. Curle.

12. *Water Polo Match: Guy's v. H. N. Eccles's Team.* Result: Guy's beaten, 6 goals to 2. Teams:—

GUY'S.—A. Guinness, H. James, E. F. Llarena, C. H. Laver, A. L. Anthony, J. York Moore, E. S. Phillips.

H. N. ECCLES'S TEAM.—G. Coombes, A. N. Other, A. N. Other, — Bevis, Graham Marshall, — Pearce, H. N. Eccles. At the close of the evening Mrs. Fagge distributed the prizes to the successful competitors.

Cricket.

GUY'S v. HORTON ASYLUM.

This match was played at Horton on Wednesday, 11th June.

HORTON ASYLUM.

Att. Roper, c Biddle, b Dixon	8
Dr. Bartlett, c Morres, b Biddle	0
Dr. Foster, b Dixon	7
Dr. Roberts, c Curle, b Dixon	0
Att. Jenner, b Harkness	42
Att. Kendall, c Harkness, b Biddle	1
Att. Mills, lbw, b Biddle	10
Att. Bambridge, not out	31
Att. Jenkins, b Biddle	40
Att. Dudley, c Bowes, b Dixon	4
Att. Larkins, b Biddle	1
Extras	16
Total	160

GUY'S.

—. Bookless, c Jenkins, b Dudley	16
A. C. M. Coxon, b Dudley	2
L. H. Dixon, b Bambridge	20
—. Morres, c Mills, b Dudley	69
—. Covell, run out	2
—. Bowes, c Bartlett, b Bambridge	0
F. Biddle, b Bambridge	0
L. Curle, b Dudley	14
A. H. Harkness, not out	91
—. Hubbard, c Roberts, b Jenner	24
—. Day-Lewis, b Dudley	15
Extras	30
Total	283

GUY'S v. FOREST HILL.

Played at Honor Oak on Wednesday, June 25th. Guy's won the toss, and by consistent batting scored 297 for the loss of six wickets. The visitors, fatigued by their efforts in the field, were dismissed for the small score of 82. We were glad to see R. Montgomery in the field once more.

GUY'S.

A. B. Bond, c Pearson, b Parker	60
A. C. Hancock, hit wicket, b Parker	7
C. Vincent-Brown, c Keddie, b Hunter	73
R. Montgomery, b Parker	20
L. H. Dixon, not out	93
A. H. Birks, c Parker, b Hunter	4
A. F. Rook, c Keddie, b Parker	5
B. F. Sampson, not out	18
Extras	17
Total (for 6 wickets)	297

A. H. Harkness, C. C. Gibson, F. J. Biddle, did not bat.

FOREST HILL.

A. L. Thomas, b Biddle	9
G. L. Betham, b Dixon	2
C. M. Keddie, c Rook, b Dixon	2
S. A. Hunter, c Harkness, b Biddle	2
A. S. Sellar, b Dixon	1
G. H. Pearson, c Bond, b Biddle	1
C. Moore, lbw, b Biddle	7
S. Wright, b Montgomery	27
C. F. Phillips, st Bond, b Rook	12
H. A. Kennard, b Montgomery	12
F. L. Parker, not out	0
Extras	7
Total	82

GUY'S v. THE WANDERERS.

Played at Honor Oak, on Saturday, June 28th. After an even game this match ended in a tie. A. C. Hancock batted finely for the hospital.

GUY'S.

A. C. Hancock, c & b Gillespie	97
A. C. M. Coxon, b Gale	28
C. Vincent-Brown, b Morley	7
L. Dixon, b Kenward	14
C. Curle, b Gillespie	31
L. Green, st Brookes, b Bradley	12
F. C. Hunôt, b Gillespie	20
A. H. Harkness, c Gale, b Bradley	7
L. R. Broster, b Gillespie	0
C. Gibson, c Gale, b Gillespie	6
F. Biddle, not out	1
Extras	13
Total	236

WANDERERS.

S. Colman, b Dixon	31
T. C. Stafford, b Harkness	26
F. S. Gillespie, b Biddle	23
R. B. Brooks, not out	79
R. Kenward, c Curle, b Biddle	1
L. S. Wells, b Dixon	3
J. U. C. Watt, c Biddle, b Dixon	16
P. G. Gale, c Harkness, b Biddle	13
E. Clark, c Broster, b Dixon	0
F. L. Morley, not out	15
Extras	29
Total	236

W. M. Bradley did not bat.

GUY'S v. THESPIDS.

Played at Malden on June 29th. This match was won by 10 runs after an exciting finish. L. H. Dixon gave a great display of batting, scoring 123 runs. Final scores—Guy's, 233; Thespids, 223.

Births.

BUTLER.—On June 24th, at 269, Goldhawk Road, Shepherd's Bush, W., the wife of J. A. Butler, M.D., of a daughter.

ELLIOTT.—On June 21st, at Sevenoaks, the wife of E. Lionel Elliott, of a son.

JACOB.—On June 22nd, at Dunamase, Shirley Avenue, Southampton, the wife of E. D. Jacob, L.D.S., of a son.

WOHLMANN.—On March 20th, at Carlisle Parade, Hastings, England, to Dr. and Mrs. Wohlmann, of Rotorua, New Zealand, a son.

Deaths.

CREW.—On June 16th, at Manor House, Higham Ferrers, Northants, John Crew, M.R.C.S., L.R.C.P., J.P., in his 77th year.

WALLACE.—On June 14th, at the Manor House, Uppingham, suddenly, Frederick Wallace, M.R.C.S. Eng., L.R.C.P. Lond.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette." Guy's Hospital, London, S.E.*

G. T. M.

GUY'S HOSPITAL GAZETTE.

VOL. XXVII., No. 654.] JULY 19, 1913. [SIXPENCE.

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Passim.

IT seems that there is at present a great scarcity of recently qualified men. Practitioners are apparently experiencing an increasing difficulty in obtaining *locums*, and are offering higher fees on the average than in previous years. Five guineas a week seems to be almost the rule this summer, and we have heard of several men who are getting six guineas, and of one who is even receiving seven guineas. Nor is it only practitioners who find it difficult to secure men for the holidays; both hospitals and infirmaries have the same trouble, and many are offering more money than was the custom in previous years.

THE causes of this shortage are many. It is partly, no doubt, due to an actual falling off in the number who have taken up medicine in recent years, partly because there are so many branches of the profession now that a larger and larger proportion of men never go into practice at all, and never do *locums* as a preliminary to so starting; and partly, we hear, because a number of men who at one time alternated between doing *locums* and being medical officers on ships, have recently started in practice for themselves in the densely-populated industrial areas. The explanation of this probably lies in the fact that the panel system ensures a man a certain small income, and so enables some who have no capital to set up with a reasonable prospect of being able at least to live until they can build up a satisfactory practice.

THERE has recently appeared in the *Hospital* a series of articles written by patients themselves under the title of "Hospitals from the Patient's Point of View." Several of these have been exceedingly interesting and should have much value for sisters and house-officers. One point which appears very strongly is the importance of securing sleep for patients, more particularly for those who are experiencing any pain or even discomfort. The patients seem to complain largely of the noises which interfered with their sleep, but it seems obvious that it is practically impossible, without private rooms, to abolish all those noises which are likely to disturb a hypersensitive patient. One is rather forced to the conclusion that in hospitals hypnotics should be given even more freely than at present, and, of course, should be given much earlier than is at present the custom. The rather doubtful depression which may follow the use of an hypnotic is probably far less harmful than the discomfort of a sleepless night, or even half-night.

ANOTHER point to which attention was drawn, and the complaint is one we have often heard at Guy's, is that the urinals supplied to patients are absurd, both in shape and size. All who have had experience with this article are agreed as to its disadvantages, and they are obvious to anyone who inspects it critically.

There is one little item in the arrangement of a hospital bed which has not apparently been commented on, and that is the "drawsheet." This simple contrivance, which is, it appears, chiefly used for economy, is in reality the secret of the comfortable bed as made up in a hospital. When properly tucked in at the sides, it remains smooth and uncreased for long periods, and it can, when required, be readjusted without any unnecessary disturbance of the patient.

FROM remarks made to us recently, apropos of our references in Passim to the Guy's Hospital Ladies' Association, we gather that many men, who ought to know better, think that the chief work of the Association lies in distributing tracts to the ward patients. This is the greatest possible mistake, for the distribution of tracts occupies no part in the various activities of the members. The Association consists of over 1,500 ladies interested in the hospital, who pay a minimum annual subscription of half-a-crown, which money is expended either in supporting the six beds and two cots, now maintained in the Hospital, or in purchasing material to be made up into garments for the patients. The members, in addition, give practical assistance by making at least two garments a year for the Hospital. The clothes supplied consist chiefly of dressing gowns and jackets for the adults and frocks for the children, and also of outfits for patients going to convalescent homes. This provision of clothes is a very important matter as any Ward Sister will gladly acknowledge, since the Hospital itself is only able to supply a minimum for the in-patients, and, of course, is not in a position to satisfy the requirements of the convalescent homes. As may be imagined the outfitting of many patients on discharge is a very frequent occurrence, when one considers the condition of the clothes in which so many come in.

NOR are the members of the Association finished with the patients when they leave the Hospital. Some of those who need it are followed up and helped in whatever manner may be practicable by the Ward Visitors. Recently we heard of a patient who had been provided with an artificial limb through the efforts of a member, and we have heard of many similar cases in which patients have been admitted to homes or obtained situations after leaving the Hospital.

As will be at once acknowledged by all who have had any experience of hospital patients, this after-care is of very great importance, and its urgency is becoming every day more widely appreciated. In one American hospital a special department has been established to take charge of this work under the name of the Social Service Department. Officially our Hospital does much good work through the Almoner, Miss Grundy, and the Samaritan Fund, and the work of the Association Visitors supplements this by its more personal character and also by the wider area over which it extends.

THESE various beneficent activities have, we feel sure, only to become well known to be appreciated by all who are interested in Guy's, and also by all who feel that they owe some duty to those who are less fortunately situated than themselves. Of course, we have not written this account merely for the information of the ignorant. It is our object to enlist the sympathies of Guy's men, and to stir them up to make the Association more widely known among their mothers and sisters. There must be many ladies interested in Guy's who would be only too willing to give up a little of their time in such valuable work. Any further information may be obtained from the Hon. Secretary, Mrs. Lauriston Shaw, 64, Harley Street, W.

WE congratulate Mr. L. A. Dunn on being elected to the Council of the Royal College of Surgeons, and Guy's on having another member of the active staff on the Council.

AS will be seen from the list of new appointments in this issue, Mr. W. Lindsay Locke, M.B., Ch.B. Ed., has been appointed Senior Medical Radiographer, and Mr. A. J. Clark, M.B. Cantab., M.R.C.P. Lond., Lecturer in Pharmacology,

this last post being, as we said in a recent issue, a new creation. Neither gentleman is a Guy's man, but they are none the less welcome on that account.

VARIOUS minor changes will take place when Dr. Pitt retires in October. Dr. Fawcett will become one of the Lecturers in Medicine, and resigns the Curatorship of the Museum. He is succeeded in this by Mr. Davies-Colley, whilst Dr. Hunt will take charge of the Museum Demonstrations in Pathology.

MR. K. H. DIGBY, Surgical Registrar 1909-11, has been appointed Professor of Anatomy in the new University of Hong Kong. We congratulate him and wish him every success in his new work. We are sure that he will worthily uphold abroad the reputation of Guy's.

SOME few months ago an appeal was made in Passim for articles from old Guy's men, especially from men in practice. As recent numbers of the GAZETTE bear witness the response to this appeal has been very generous, and we offer our hearty thanks to our contributors. We hope that many more men will be stimulated by their example, and that we may look forward to a constant supply of similar articles.

THERE is at present an opportunity for a recently qualified man to obtain a year's experience in a hospital in China. The hospital is in connection with a Mission, and is at the treaty port of Wenchow province of Chekiang. The appointment is one which has many attractive features since, in addition to experience in many diseases not seen in this country, a man would have the opportunity of seeing a little of China and the Chinese, and would be able to go out *via* Siberia and return *via* the Suez Canal. Surgical work is, we understand, to be had in abundance. Any further particulars may be obtained from Dr. W. E. Plummer, 24, Granville Road, Sidcup, Kent.

The Old Operating Theatre.

GUY'S men cannot fail to observe that part of the secret of their *alma mater's* air of perpetual youth is explained by the removal of those "disharmonies" which would have impaired the proper discharge of her functions.

Amongst the latest instances of this beneficent surgery is the recent demolition of the old wooden operating theatre. Although actually it was rather less than fifty years old, it perpetuated an older type that realised the term "theatre" better than does the newer arena of operation constructed in accordance with modern ideas.

In former times the accommodation of a greater number of spectators than would be now desirable, was necessary for more than one reason. To what extent the amount and range of surgery have increased within quite recent years is to be measured by the number of theatres now regarded as indispensable where, about fifteen years ago, this one alone served the whole surgical needs of the hospital; whilst a century ago but one day in the week was set apart for operating. The average student, therefore, while his opportunities for actual participation were fewer, had the more leisure to devote to watching the performance of others. Indeed, until well into the last century there was a large group of students who had no first-hand acquaintance with surgical practice during their pupilage at the hospital. Such knowledge, other than theoretical, of surgery as these hospital "pupils" ever acquired was obtained from the minor surgery that came their way whilst serving their apprenticeship to a general practitioner; and they were, therefore, eager to gather as much practical information as possible by observing hospital operations from the higher places of the theatre.

The "dressers"—qualified men undertaking a post-graduate course in surgery—and the apprentices attached to the hospital surgeons enjoyed special treatment. Even when their own surgeon was not operating, it was their privilege to stand in the well of the theatre and thus obtain a nearer view of the proceedings. How the surgeon-in-charge ever contrived to perform anything in such a crowd passes understanding, for, apart from his own body-guard of four dressers and as many apprentices, he had to contend for elbow-room amongst the mob of dressers and apprentices belonging to his colleagues upon the Staffs of the two Borough Hospitals; and frequently his colleagues themselves were in attendance.

At St. Thomas's Hospital a notice, dated 1796, was displayed in the operating theatre authorising this arrangement:—

"*Apprentices and the Dressers of the Surgeon who operates, are to stand round the Table. The Dressers of the other surgeons are to occupy the three front*

Rows. The Surgeons' Pupils are to take their Places in the Rows above.

Visitors are admitted by permission of the Surgeon who operates."

In the earlier days of Guy's many a famous surgeon operated in the theatre that existed on the site of that which has just been destroyed. It may be safely assumed that such a place was set apart at the very beginning for Croft and Cooper and that there Hasell Cradock first "cut for stone" at Guy's in 1733; and that, before 1753, Samuel Sharp had there elaborated his "New Method of opening the Cornea in order to extract the Crystalline Humour," and his operations, in Cheselden's manner, upon sarcocele, for ligature of the tonsils, and lateral lithotomy. His apprentice, Joseph Warner, afterwards carried this school of operating further.

Not always were the surgeons so confident in performance. William Cooper was over-sensitive to the sufferings of his patients, and when a subject for amputation jumped from the table and fled the hospital, he exclaimed, "By God! I'm glad he's gone!"

After Astley Cooper's arrival, Thompson Forster and the younger Lucas rarely operated except in his presence, and he himself declared that, like his friend Cline, he gained more reputation by assisting his colleagues than by his own operations, "for they were always in scrapes, and we were obliged to help them out of them." It was said that "the moment Astley Cooper entered and the instrument was in his hand, every difficulty was overcome, and safety generally ensued." His very first operation after appointment as surgeon to Guy's was to put Forster into the right way after he had got into difficulties in operating for stone.

Of "Billy" Lucas it is recorded that "he was neat-handed but rash in the extreme, cutting away most important parts as if it was only skin, and making us always shudder from apprehension of his opening arteries or committing some other errors." Once, having begun a circular amputation, he had occasion to move to the opposite side of the table, and absently continued, shaping the covering for the lower fragment and leaving the bone of the stump bare and projecting.

With Sir Astley came a new era in surgery at Guy's. Although the scene of his lecturing was at St. Thomas's, it was at Guy's that his operative triumphs were achieved; the successful proximal ligature of a carotid aneurism in 1809, the ligature of the femoral for popliteal aneurism, and, in 1816, the famous ligature of the aorta which the patient survived for forty hours. For the first time amputation at the hip was performed by him in 1824, the whole operation, of course without anæsthesia, being completed with all dressings in the space of half an hour. It was the hardest day's work, said the plucky patient, that he had ever gone through, as it was, very nearly, Sir Astley's also.

The scene on operating day must have been impressive: "the large theatre at Guy's, crowded to the ceiling, the profound silence obtained on his entry, that person so manly and so truly imposing, and the awful feeling connected with the occasion" were unforgettable. "The elegance of his operation, without the slightest affectation, all ease, all kindness to the patients, and equally solicitous that nothing should be hidden from the observation of the pupils, rapid in execution, masterly in manner, no hurry, no disorder, the most trifling minutiæ attended to, the dressings generally applied by his own hand," were all characteristic of his method.

One of the contemporary surgeons of St. Thomas's said of him, "Sir, it is of no consequence what instrument Mr. Cooper uses, they are all alike to him, and I verily believe he could operate as easily with an oyster-knife as the best bit of cutlery in Laundy's shop."

On Fridays, just before one o'clock, the theatre began to fill. The surgeons of St. Thomas's, who had started an hour earlier, usually went over after having done their work, and their arrival was commonly waited for by the Guy's surgeon. The theatre, up two flights of stairs, was quite inadequate for the accommodation of all the pupils from the United Hospitals who desired to attend. There was a "semi-circular floor, rows of semi-circular standings rising above one another to the large skylight. On the floor, the surgeon operating with his dressers, the surgeons and apprentices of both hospitals and the visitors stood about the table upon which the patient lay, and so placed that the best possible view was given to all present. The floor was separated by a partition from the rising standing-places, the first two rows of which were occupied by other dressers, and behind a second partition stood the pupils packed like herrings in a barrel, but not so quiet, as those behind were continually pressing on those before, often so severely that several could not bear the pressure and were continually struggling to relieve themselves of it, and had not infrequently to be got out exhausted. There was also a continual calling out of 'Heads! Heads!' to those about the table whose heads interfered with the sightseers, with various appellatives. . . The confusion and crushing was at all times very great, especially when any operation of importance was to be performed, and I," said Mr. J. F. South, "have often known even the floor so crowded that the surgeon could not operate till it had been partially cleared."

The violent scrambling efforts of the pupils to gain entrance and their distribution in their proper places often led to severe contests and even fighting with the hospital servants to whom this duty was assigned.

Sir Astley found a worthy successor in Aston Key, who, as early as 1823, had tied the subclavian for axillary aneurism. Such measures had a vastly different importance in those pre-anæsthetic days, and to some extent Key himself helped to usher in the new era in surgery.

The news of the anæsthetic value of ether reached England in December, 1846, and was at once employed in an operation by Mr. Liston, and very shortly afterwards Aston Key introduced its use at Guy's. Sir James Simpson's discovery of the uses of chloroform was published in 1847.

In this connection it is interesting to note that in 1842, before either of these discoveries had been made, an eminent surgeon named Ward had performed at Guy's an amputation through the thigh upon a patient under complete anæsthesia induced by hypnosis. He subsequently read a paper on the subject before the Royal Medical Chirurgical Society; but Mr. Ward's views were too much in advance of his time, and the paper was ordered to be expunged from the records of the society.

Aston Key's most spectacular operation was undoubtedly the removal of the famous elephantiasis scroti from the Chinaman, Hoo Loo, in 1831. So large a number of spectators had assembled that Sir Astley announced that the operation would take place in the large Anatomical Theatre, and there the mass, weighing over 36 pounds, was cut away after an operation lasting an hour and three-quarters. The patient unfortunately succumbed from hæmorrhage, although transfusion with eight ounces of blood from a medical pupil had been resorted to. The tumour is to be seen in a large jar on the ground-floor of the Gordon Museum, and a portrait of the patient before operation hangs in the Curator's Room.

Key's contemporary, John Morgan, another first-rate surgeon, performed some of the earliest amputations by the flap method. Even in those days when rapidity was specially desirable, Morgan was remarkable as a speedy operator.

Sir Astley's nephew, and Key's brother-in-law, Bransby Cooper, is not to be reckoned among Guy's greatest surgeons. It was a report on a lithotomy of his that led to an action for libel against the *Lancet*, and a long-standing feud between the hospital authorities and Wakley, the editor of that journal. Apparently the patient had been tied upon the table for a whole hour whilst the stone was sought for, and had died thirty-six hours later. The action was tried in 1828, and was decided in Bransby's favour, although he was only awarded £100 in damages in place of the £2,000 for which he had claimed.

But the *Lancet* was not to be silenced altogether, and when, later, another subject for lithotomy took fright and escaped from Guy's to St. Thomas's, the famous epigram was published:—

"When Cooper's nevey cut for stone,
His toils were long and heavy;
This patient greater skill has shown,
For he cut Cooper's nevey!"

Edward Cock, appointed assistant-surgeon in 1838, was another nephew of Sir Astley Cooper, who in his day put up a fine record and evolved an operation of his own. He died as recently as 1892.

Cooper Forster, who became full surgeon in 1870, performed the first gastrostomy seen in this country.

The first nephrectomy in England was done by Arthur Durham in 1872, but the patient, a woman who had suffered from a movable kidney, succumbed to shock and secondary hæmorrhage within a day or two. It remained for Mr. Clement Lucas to repeat the operation with complete success. On February 17th, 1880, a suppurating tuberculous kidney was removed from a man, who afterwards made a good recovery. This operation was, however, conducted in the private room attached to "Philip," the ward now represented by "Addison."

But to follow the surgical record of Guy's further would be to enumerate the achievements of surgeons who, like Mr. Lucas, are still flourishing.

Lord Lister's epoch-making discoveries were made about 1860, but only began to find general acceptance after a lapse of several years. The Guy's Theatre recently demolished was constructed in 1867 on lines closely resembling those of its predecessor, and in its day saw a deal of sound antiseptic surgery. To the more exacting demands of Asepsis it was less well adapted, and for modern methods a different ideal has been evolved. But now that it has at last become no more than a memory, it is well that the good service of other days should not be forgotten.

Change of Address.

Miss L. E. A. Campion, from Guy's Nursing Institution, St. Thomas's Street, to the National Hospital, Bloemfontein, O.F.S., South Africa.

N. B. Clowes, M.R.C.S., L.R.C.P., from 45, London Road, to Aubrey House, Bath Road, Reading.

Kenelm H. Digby, M.B., B.S., F.R.C.S., from Malvern House, Bowdon, Cheshire, to the University, Hong Kong.

T. E. Holmes, M.D., B.C., from Knighton, Leicester, to "Thorncliff," St. Andrew's Road, Nottingham.

B. Isaacs. L.D.S., from Petherton Road, Canonbury, London, to Coblentz Villa, Breda Street, Cape Town.

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J. J. Daly Richardson, from 67, Rusthall Avenue, to 70, Abinger Road, Bedford Park, W.

C. H. Rippmann, M.D., B.C., from Queen Charlotte's Hospital, to 77, Upper Berkeley Street, W.

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W. Leslie Webb, M.B., B.S. (Lond.), from Guy's Hospital to Uganda Medical Service.

Enlargements of the Spleen.

CLINICAL LECTURE BY HERBERT FRENCH.

THE DIFFERENTIAL DIAGNOSIS OF ONE VARIETY OF SPLENIC ENLARGEMENT FROM ANOTHER.

(*Continued from page 277.*)

Having made up one's mind that the tumour felt in the abdomen is an enlarged spleen, the next question is as to the nature and cause of the enlargement. We have not time to-day to discuss every possible enlargement of the organ, and I propose to delete from our list all the minor enlargements such as those met with in typhoid fever, some cases of influenza, septicæmia, simple malnutrition, and rickets in children, pneumonia and other similar fevers, lardaceous disease, and general tuberculosis; for in all of these the splenic enlargement is seldom great, and in any case it is, as a rule, a minor point in comparison with the other symptoms present. We may confine ourselves to those conditions in which the enlargement has been or may be considerable, or even huge. The main causes of great enlargement of the spleen are the following:—

1. Splenomedullary leukæmia (largest of all).
2. Lymphatic leukæmia (moderate only, as a rule).
3. Pernicious anæmia (generally slight, but may be considerable).
4. Splenomegalic polycythæmia, or Vaquez's disease (moderate or considerable).
5. Hodgkin's disease (moderate only, as a rule).
6. Splenic anæmia (may be considerable).
7. Cirrhosis of the liver (generally slight, but may be considerable).
8. Infective endocarditis (seldom more than moderate).
9. Malaria and other tropical fevers, especially Kala Azar (moderate, as a rule, but may be huge).
10. Pseudoleukæmia infantum, von Jaksch's disease (may be huge).

Before proceeding further, I should like to draw particular attention to the fact that the above list contains no mention of gumma of the spleen, sarcoma of the spleen, carcinoma of the spleen, or hydatid disease of the spleen. From your point of view all these things are practically non-existent. When they do occur they are pathological curiosities, and are put into museums, and you will probably never meet with any of them in practice. It is a particularly remarkable fact how very seldom the spleen contains a secondary mass or even a small nodule of malignant growth; there may be masses of growth attached to the peritoneal surface of the spleen when carcinoma has spread to the peritoneum generally, but it is an almost unknown thing, at any rate from the point of view of everyday practice, to find a considerable enlargement of the organ due to either a primary or a secondary new growth. I mention this particularly, for I have found sometimes that students, notwithstanding their attendances in the post-mortem room, do not always realise it.

Turning now to the conditions we have just enumerated as the causes of considerable enlargement of the spleen, what are the steps one would take in differentiating between one and another? The first thing that one should do is to make a complete blood count, that is to say, one should enumerate the red corpuscles, estimate the hæmoglobin, enumerate the white corpuscles, make a differential leucocyte count, and at the same time examine the condition of the red cells in blood films. There are, however, only five of the above conditions in which the blood examination serves to give the diagnosis, that is to say, in which the blood picture is pathognomonic of the disease from which the patient is suffering, and these are: splenomedullary leukæmia; lymphatic leukæmia; pernicious anæmia—in which, by the way, the spleen is generally not enlarged at all, and only in exceptional cases attains any considerable size; splenomegalic polycythæmia; and malaria. In the remainder the blood count does not give the diagnosis, but serves to help it by excluding the five conditions we have just enumerated in which the blood picture is positive. Please remember this particularly in connection with Hodgkin's disease; the blood examination will *not* give the diagnosis of Hodgkin's disease, but will assist the diagnosis by excluding leucocythæmia, for example, leaving Hodgkin's disease amongst the possibilities or probabilities. There are no pathognomonic changes in the blood in Hodgkin's disease.

What, then, are the characteristic blood changes in the five varieties of splenic enlargement in which blood examination gives the diagnosis? Taking the last on the list first, *malaria* is diagnosed partly from the fact that

the patient has been living in a malarial district, and has had periodic attacks of pyrexia with rigors familiar to you as ague, partly by the fact that the pyrexial attacks are amenable to treatment by quinine, but the diagnosis has not been established unless one discovers in the blood the characteristic protozoa which have two main forms, namely, the so-called "rings" in the case of ordinary tertian and quartan malaria, and the crescents in the case of the æstivo-autumnal fever. The presence of these clinches the diagnosis, and you will see under this microscope here a blood film which shows the ring-form of tertian malaria. It is important to realise that these parasites are best seen in films taken just before or at the time the rigor begins, and also that if quinine has been given to the patient the protozoa are absent from the peripheral blood even though the febrile attacks continue, so that the blood films should be prepared before quinine has been given. There is, however, another almost characteristic blood change in malaria, and that is that the leucocytes instead of increasing, tend to diminish so that there is what is called leucopenia, whilst at the same time in the differential leucocyte count there is a marked relative increase in the large lymphocytes, such as, in association with leucopenia, is exhibited by very few other conditions. This relative increase in the large lymphocytes may be demonstrated even after no protozoa are to be found in the blood film as the result of the giving of quinine.

Two other points in the diagnosis of malaria that may sometimes be serviceable are: that owing to the great destruction of blood that takes place in bad cases, much free brown pigment is sometimes to be found in the circulating blood, and similar pigment is demonstrable in the centrifugalised deposit from the urine; and that urobilinuria is very pronounced at the time the malaria is active, disappearing when the attacks are in abeyance. I show you here the typical eosin-like fluorescence of the zinc acetate test for urobilin, and with the spectroscope you will see the dark absorption band between the green and blue parts of the spectrum.

It has been realised of recent years that by no means all those ague-like fevers that occur in the tropics, and particularly in India, associated with enlargement of the spleen, are really malaria; and one in particular has been differentiated from the rest; it is called Kala-Azar, and it is endemic in Assam, from whence cases may come to Great Britain. In this disease no protozoa may be found in the peripheral blood, but by using a hollow needle and syringe, puncturing the spleen, and preparing films from the liquid so obtained, pathognomonic bodies, called Leishmann-Donovan bodies, will be found to establish the diagnosis. This, however, is perhaps of little interest to you at the present moment, for comparatively few of you will have to do with essentially tropical diseases, and Kala-Azar never occurs in Great Britain unless it has been imported from some locality in which it is endemic, particularly Assam.

The two so-called blood-diseases characterised by considerable or even huge enlargement of the spleen that you will all meet with now and then are the two chief forms of leukæmia, namely, the splenomedullary and the lymphatic. In neither of these do the red corpuscles exhibit pathognomonic changes, though as the case progresses a considerable and finally even an extreme degree of anæmia is reached; the diagnosis depends not upon the red, but upon the white corpuscles of which in each type of this disease there is an enormous increase; the latter may be so extreme that the blood contains over one million white corpuscles per cub. mm., and in one patient who was in the wards a few years ago the red corpuscles could not be counted until one had first enumerated the total corpuscles—red and white together—and then the total leucocytes; after which, by deducting the leucocytes—which were over 1,000,000 per cub. mm.—from the red and white corpuscles together, one found that the red corpuscles were, in round figures, 2,000,000 per cub. mm. Such cases are exceptional, but it is quite common to find 300,000 leucocytes per cub. mm. in spleno-medullary leukæmia, the figures being generally lower in the lymphatic form, in which, however, over 100,000 per cub. mm. are not uncommon. Considerable enlargement of the spleen associated with any degree of leucocytosis such as this at once suggests the diagnosis of leukæmia whatever the changes in the red corpuscles may be, and the diagnosis is clinched and the one main type of leukæmia distinguished from the other by making a differential leucocyte count. In the lymphatic form there is a tremendous relative increase in the lymphocytes generally in those of the small or intermediate kinds, and in a typical count 90 per cent. or more of all the white corpuscles present may be lymphocytes. No other disease is known to produce so marked a lymphocytosis in

association with so great a total increase of the white corpuscles in the blood, and when at the same time there is generalised enlargement of the lymphatic glands as well as of the spleen, the diagnosis is very easy. In the splenomedullary type of leukæmia blood films exhibit considerable numbers of a kind of corpuscle not present in ordinary blood at all, namely, myelocytes, of which I show you pictures here. They are, in some respects, similar to large lymphocytes, but differ from the latter in that the protoplasm instead of being hyaline, is full of granules which in some cells stain blue, in others red, whilst at the same time the nucleus is round and not multi-lobular as in the case of polymorphonuclear leucocytes. These myelocytes may amount to anything from 20 to 60 per cent. of all the corpuscles present, and there is no other disease but spleno-medullary leukæmia that will produce a tremendous increase in the total leucocytes in the blood in association with great enlargement of the spleen and a differential count exhibiting such large numbers of myelocytes. A few myelocytes, 1 or 2 per cent. of all the corpuscles present, may be found in pernicious anæmia, splenic anæmia, and Hodgkin's disease, but they never reach 20 or more per cent. as they do in spleno-medullary leukæmia. I must mention, however, that there are certain atypical cases of leukæmia, the best known of which is one in which the blood exhibits the combined characters of those of the lymphatic and of the spleno-medullary types; these are sometimes spoken of as mixed leukæmia. When X-ray treatment of the spleen has been adopted in the spleno-medullary type of the disease the total leucocytes per cubic millimeter of blood have frequently been known to become reduced almost to the normal, and then one has the phenomenon of leukæmia without leucocytosis, but even here the diagnosis may be made from the differential count for myelocytes are still a prominent feature in the blood film as a rule. In very rare cases leukæmia has been met with at a stage in which, without any X-ray treatment having been adopted, there is no very great leucocytosis, but when this is so, the great enlargement of the spleen and the preponderance of either myelocytes or of lymphocytes in the films may suggest the diagnosis. if they do not, then the diagnosis must remain in doubt unless as time goes on the total leucocytes per cubic millimeter of blood are found to increase as they do in the ordinary type of the disease.

In pernicious anæmia the most characteristic point about the blood is that, although both the hæmoglobin and the red corpuscles become reduced very greatly below the normal, the hæmoglobin falls less rapidly than do the red cells, so that each red corpuscle contains a relatively greater amount of hæmoglobin than the normal red corpuscles do.

The ratio of hæmoglobin to red corpuscles is spoken of as the colour index. In normal blood containing 100 per cent. of hæmoglobin and 100 per cent. of red corpuscles, the colour index is 100/100, or 1; in pernicious anæmia, if the red corpuscles are diminished, perhaps to 20 per cent. of normal, the hæmoglobin may be reduced only to perhaps 30 per cent. of normal, so that the colour index is 30/20, or 1·5, and it is this high colour index in the presence of pronounced anæmia that is the most characteristic diagnostic sign of the disease.

I can say only a few words about the remaining diseases in our list above, for we are already near the end of our lecture time.

In Vaquez's disease, or splenomegalic polycythæmia, the patient is generally an adult who has been suffering from gradual deterioration of energy and health, and ultimately develops shortness of breath and more or less cyanosis, and upon examination one finds enlargement of the spleen, and in the blood count, whereas the white corpuscles may be normal, the red corpuscles, instead of being 5 million per cub. mm., may number 7 million, 8 million, or more. It is a rare malady, but since it has been described, more and more cases of it are being recognised; the enlargement of the spleen and the polycythæmia without other blood changes are characteristic.

Hodgkin's disease is closely related to lymphadenoma, on the one hand, and to lymphosarcoma, upon the other, and there are also cases which show that there is possibly a relationship between it and lymphatic leukæmia. The enlargement of the spleen is often only slight; enlargement either of one or two groups of lymphatic glands or possibly of all the lymphatic glands in the body is generally a most prominent feature of the case. When these glands enlarge very rapidly, and the patient dies soon in the way he would from malignant disease, one may describe the condition as being lymphosarcoma; when enlargement of the lymphatic glands in one or more groups is very marked, but the spleen cannot be felt, the term lymphadenoma is employed. When besides all

the lymphatic glands there is enlargement of the spleen, one has the disease in the form first described by Hodgkin. Some observers assert that there is an entire difference between Hodgkin's disease, or lymphadenoma, on the one hand, and lymphosarcoma, upon the other; but clinically it is very difficult to draw the distinction; the three seem to differ from one another rather in degree than in kind; when there is no enlargement of the spleen, lymphosarcoma is differentiated from lymphadenoma by its relatively rapid fatal course; lymphadenoma on its part is distinguished from the Hodgkin's type of the same disease by there being no enlargement of the spleen in the former and considerable enlargement in the latter. In all three there are no pathognomonic blood changes. There may be progressive and ultimately severe anæmia of the chlorotic type, but if there is any leucocytosis at all it is seldom more than moderate, and although the differential count of the leucocytes may not be normal, it seldom presents any features that may be called pathognomonic.

Splenic anæmia is possibly a real disease; many cases that are labelled splenic anæmia, however, ultimately turn out to be examples of cirrhosis of the liver in which before the other symptoms of cirrhosis are pronounced enlargement of the spleen has been recognised, and there is more or less simple anæmia. The fact that many cases originally regarded as splenic anæmia ultimately turn out to be cirrhosis of the liver was first drawn attention to by Banti, and the condition is sometimes spoken of as Banti's disease. In cirrhosis of the liver itself the enlargement of the spleen is seldom great, but occasionally it is enormous; this is particularly true when the cirrhosis develops in children or young people in whom there is a type, possibly congenital and not alcoholic, in which splenic enlargement is so pronounced a feature that it has earned the name splenomegalic cirrhosis.

I show you here some diagrams of a case of this kind that was reported by Dr. Frederick Taylor in the Guy's Hospital Reports. Continuous slight jaundice is sometimes a marked feature of these cases, and more than one member of the same family may be affected in the way one would expect if it were due to some congenital cause. Another curious feature of the case is that the fingers are very often clubbed in much the same way that they are in cases of fibroid lung. The blood changes are negative.

Infective endocarditis is always difficult to diagnose, but it is a very important point to remember that the spleen very seldom indeed becomes clinically enlarged in ordinary cases of heart failure, such as one meets with in connection with straightforward mitral stenosis for example. In infective endocarditis, on the other hand, the spleen is very often slightly and often considerably enlarged, so that I should like you to remember that when you are confronted with a cardiac case, and you find decided enlargement of the spleen, you should always be suspicious that you have not to deal simply with mechanical failure, but that there is the much more serious lesion of infective endocarditis in addition. The other points to be on the watch for in the diagnosis of such a case are spontaneous hæmorrhages of any kind, evidence of infarction of the kidneys, spleen, or of embolism in a peripheral artery, optic neuritis, which is present in a small but decided proportion of the cases, progressive anæmia, periods of pyrexia which may be considerable, but are often slight, and may pass unrecognised unless a proper temperature chart is kept; sudden and radical changes in the cardiac bruits, such, for instance, from blowing to musical, or vice versa. A very important means of assisting the diagnosis is to withdraw from a vein a sufficient amount of blood for bacteriological cultivation, obtaining it by aseptic, but not antiseptic, measures, and finding in this blood the organisms which are the cause of the infective endocarditis.

I am sorry that these remarks have had to be made so briefly; the shortness of the time is responsible for this. You will be asking what has the lecture so far had to do with the case I originally showed you? This brings us to the last item in the list above, namely, pseudo-leukæmia infantum, first described by von Jaksch, and often referred to as von Jaksch's disease. You will now and then come across a case in an infant or child who is very anæmic and ill, and in whom upon physical examination you can find nothing else the matter but great enlargement of the spleen. So big may this organ be that you will at once think of leukæmia as a possible cause; and it would be the probable diagnosis were the patient an adult. Leukæmia itself does occur in children, especially the lymphatic form, but it is much less common at this age than it is in adolescents and adults. You will make a blood examination, and you will find a considerable degree of anæmia of the chlorotic type, but as regards the leucocytes instead of their

numbering scores or hundreds of thousands per cub. mm., as they do in most cases of leukæmia of the splenomedullary type, you will find either no increase at all or a rise to only so moderate a figure as perhaps 20,000 or 30,000 per cub. mm. In the differential leucocyte count you will find that the lymphocytes amount to 45 or 50 per cent. of normal, and you will wonder whether the patient has not really got lymphatic leukæmia; but you will bear in mind that the lymphocytes are always relatively more numerous in children than in adults, 40 per cent. of all the lymphocytes present being a common figure in normal children, whereas 25 per cent. would be more normal for an adult. If children are ill from any cause, even from something relatively simple such as whooping cough, small lymphocytes frequently amount to nearly half the corpuscles present. Remembering this, you will be chary of diagnosing lymphatic leukæmia, and you will remember this disease which simulates leukæmia until a blood count is done, is then found not to conform with the blood picture of the latter and so earns the title of pseudo-leukæmia infantum. Some think that it is related to rickets, others that congenital syphilis is a factor in its causation; and not a few of these children may exhibit signs either of rickets or of congenital syphilis, or of both. There has been much discussion as to whether either or both are really causal factors, and the question has not yet been settled. The reason why I want you to be very clear in distinguishing pseudo-leukæmia infantum from true leukæmia is that whereas to excise the spleen in leukæmia has hitherto been tantamount to disaster and a rapidly fatal ending of the patient's life, excision of the spleen may actually cure not a few cases of von Jaksch's disease. The operation may be difficult, but sometimes it is very easy, and in conclusion of our lecture I show you here another patient who will appear even to those of you who are nearest to him to be a normal boy. He is well known in Clinical Ward as "Bogie"; he is six years of age, and until August in last year he had all his life been an extreme invalid with a yellow, waxy-looking skin, a big abdomen in which one could feel the spleen coming down to the iliac fossa, and he had an anæmia which you can scarcely appreciate from his present colour or even figures such as the following: his red corpuscles measured only $1\frac{1}{2}$ million per cub. mm., the hæmoglobin only 25 per cent. of normal; the leucocytes were slightly increased in total numbers and the lymphocytes were 50 per cent. of the total, but there was nothing pathognomonic about the differential count.

"Bogie" was a case of von Jaksch's disease. He had been in other hospitals besides Guy's; he gave a positive Wassermann reaction, so that congenital specific disease was present. He had consequently been treated not only with iron and with arsenic in increasing doses, but also with mercury and potassium iodide; and had received injections of Salvarsan, but without any apparent improvement in his blood condition or general health. He had had various other kinds of treatment such as would have led to improvement in most cases of pernicious anæmia; nothing appeared to do him any good. It was clear that left to himself he was a useless invalid, almost certain to die soon; and I asked Mr. Philip Turner to see him with me with a view to excision of the spleen. Mr. Turner agreed with me that as everything else had been tried first, the operation was justifiable. I would go further than this now and say that the operation is absolutely indicated in a similar case, for not only did he stand the operation itself well and make a speedy recovery from it, but within two months his anæmia, which had hitherto resisted all other forms of treatment, had practically disappeared. The operation was in September and before Christmas this boy, who had hitherto been practically confined to bed was going to school, and I show him now and you can all see his firm limbs, his healthy abdominal scar and his chubby face; he is apparently cured. You will realise from him the importance of being able to recognise von Jaksch's disease and of distinguishing it from leukæmia and other forms of splenic enlargement.

Organ and Vocal Recital.

On Sunday, July 13th, a Recital was given in the Chapel, after Evensong, by Miss Gladys Moger and Mr. W. Denis Browne. It is hoped that similar recitals may be given once a month in future, and all who are interested in music may be recommended not to miss them. Miss Moger's beautiful voice was heard to the greatest advantage, particularly in Dvoràk's "Bible Songs," and "O had I Jubal's Lyre." She earned the warm gratitude of all who were fortunate enough to hear her for her kindness in coming.

The programme was as follows:—1. Choral Prelude on the tune "Dundee" (Parry), Mr. W. Denis Browne. 2. (*a*) "With Verdure Clad" (Haydn). (*b*) Three Bible Songs (Dvoràk). (*c*) Legend (Tschaikovsky). (*d*) "O had I Jubal's Lyre" (Handel): Miss Gladys Moger.

The Treatment of Psoriasis.

By H. W. BARBER, M.B., B.C., Arthur Durham Travelling Student.

During a month spent at the Saint Louis Hospital in Paris, I happened to see a number of cases of psoriasis, and it was also my good fortune to hear an exceptionally clear and instructive lecture on the subject by M. Brocq, whose clinic I attended. Moreover, since I have been in Hamburg, I have met with several good examples of the disease.

Therefore, with no pretension of saying anything original or new, I have chosen it as the subject of my first article for the Gazette.

Everyone must admit that there is a certain fascination about the disease. A typical eruption looks guileless enough, and innocent of any etiological obscurity; but a blatant manifestation often betokens a subtle cause, and, in spite of elaborate research and speculation, an entirely satisfactory and convincing theory concerning the origin of psoriasis is wanting. And for this reason, no doubt, its prevention and cure are often anything but easy. In fact, almost every mode of treatment has very marked drawbacks; and, while admitting that scrupulously careful hygienic measures will do much to prevent recurrences, it is extremely difficult, if, indeed, possible, to enforce such upon patients of the lower classes, among whom periodical relapses are the rule.

Undoubtedly, the etiological aspect of the disease is the most interesting, affording admirable practice for the manipulation of pros and cons, and for the indulgence of theoretical reasoning. And I shall later put forward a purely hypothetical theory on this point—a theory that would bring psoriasis into line with other diseases of unproven origin, and one which I hope eventually to justify by a series of experiments.

With regard to its differential diagnosis and its histological characteristics, success in the former depends upon instinct and experience, and a knowledge of the latter is at present of no particular practical value. Moreover, anything that I could say about either is better gleaned from authoritative sources.

There remains then the question of treatment. As I have already said, this leaves much to be desired, but it is usually possible to clear an eruption in from three to five weeks, and much may be done to prevent its recurrence. In this first article, therefore, I have tried to describe, as clearly as possible, some of the best methods in vogue, laying especial stress on what I have myself seen, and in no wise pretending to give anything approaching a complete review of so debatable a subject.

Treatment.

The more I see of psoriasis, the more convinced am I of the existence of an elusive element in its composition, which plays an essential, even if subsidiary, part in its production. And the fact that it is possible to cure the disease by local applications alone in no way affects such a view. Few people seem to realize that it is at least reasonable to suppose that substances, such as chrysarobin, pyrogallol, coal and wood tar, ichthyol, salicylic acid, and mercury, when applied to the skin, especially to hypervascular and diseased areas, act not only locally, but also throughout the system. That some, at least, are absorbed is, of course, beyond question.

Their common feature is their "antiseptic," or, perhaps, in some cases "antitoxic" action, and it is interesting to note that nearly all the internal remedies, which have seemed to have a beneficial action, possess the same characteristic. Arsenic and mercury, turpentine, salicin and the salicylates (Crocker), carbolic acid (Kaposi), balsam of copaiba (Hardy and M'Call Anderson)—are they not all of this nature? Therefore, on theoretical grounds, as well as from what the experience of generations of physicians has taught, I cannot agree with those who look upon psoriasis solely as a local affection, which is cured by the purely local action of certain drugs; and I make no apology for considering its treatment under the customary three headings:—General, Internal and External.

General Treatment. Helva was of the opinion that psoriasis is, in a sense, a penalty of good health, and it is certainly true that not only are many, if not most, psoriatics otherwise apparently perfectly well, but, in many cases, their general health seems at its best during their attacks. On the other hand, the supporters of the neuropathic hypothesis of the disease maintain that it is usually associated with an irritable nervous system, being often accompanied by disorders such as asthma, in which the neuropathic factor is a strong one. Both views are the result of large clinical experience, and therefore we can merely say that psoriasis may occur either in robust or in unstable persons. Another rather prevalent idea is that it is prone to appear in people "with the gouty or rheumatic diathesis," and finally there is some evidence to show that acquired and hereditary syphilis may be predisposing causes.

The indications for general treatment, therefore, depend in part on the type of patient. Thus, if a neurotic element is present, especially if accompanied by insomnia, sedatives are indicated, together with, in a few cases, complete rest in bed. Brocq recommends bromides, iodides, and valerian. In the "gouty" and "rheumatic" cases the same author advises salicylate of sodium, alkalies, iodides, diaphoretics, diuretics, and a diminution in the amount of meat taken. Moreover, both he and Bulkley consider that a quasi-vegetarian diet is often of great service in subduing and preventing the attacks. The significance of this will be considered in another place, and also the relationship of the disease to syphilis.

Not only, however, must the type of patient, but also the type of eruption be considered. For acute cases complete rest is of great importance, and, as Brocq says, the most intractable ones often quickly clear up when the patients can be persuaded to stay in bed, and submit to a hospital régime. On the other hand, in ordinary

cases, vigorous exercise, a bracing climate, and even when practicable, spa treatment are usually indicated.

Internal Drug Treatment. The administration of arsenic is the most widely recognized method of internal treatment. Unfortunately, Vidal was probably right in saying that small doses are useless; increasing doses, therefore, are consequently required. The fact that toxic effects may arise, leading soon to peripheral neuritis and hyperkeratosis, necessitates careful regulation of the dosage. I do not think that I have ever seen disagreeable symptoms ensue in any of the psoriasis patients at Guy's, but the danger undoubtedly exists. It is generally agreed that in acute cases, as with eczema, arsenic usually does harm, and that its action is best seen in the "torpid" or chronic forms of eruption. Many physicians prescribe the drug more or less as a matter of routine in ordinary cases, and no doubt it can be given safely and with benefit in most of these. At the same time the remarks of Audry—a recognized authority on the disease—are worth quoting. He says in his "Traitement des Maladies Cutanées," after commenting on the untoward symptoms that may result from the arsenical treatment:—"Personally, I have almost entirely abandoned the use of arsenic, together with injections of cacodylate of sodium; at the same time the latter may be of service ($\frac{1}{8}$ gr.—$1\frac{1}{2}$ gr. per day), and it is recognized that the cacodylates appear to have a therapeutic action distinct from that of arsenic itself" (Sir Thomas Fraser, however, denies this). "I must add that atoxyl (3 grains as a subcutaneous injection every two days) has recently afforded me some very good results in cases of psoriasis, which were too irritable to tolerate efficient local measures."

It is, perhaps, true that the dangers and drawbacks of arsenic have been exaggerated by some authors, but it seems to me that it is at least worth while in most cases to withhold the drug until the external treatment has had a thorough trial.

Methods of administration. (*a*) *By the mouth.*—1. As Fowler's solution. This is the usual method in England and in many places on the Continent. It may be given as follows: Begin with 8–10 minims per diem, and increase the dose by 2 minims daily, if well tolerated, until 40 minims daily are being taken. Having reached this amount without toxic effects, the dose may be maintained for ten days, if possible, and then gradually reduced by 2 minims each day until the initial dose is arrived at.

Of course, this method is only given as a type; individual tolerance is very variable as regards arsenic, and the rate of increase of the doses depends entirely upon this.

2. Brocq gives the following mixture:—

R.	Sodii arseniatis	$1\frac{1}{2}$ gr.
	Aqua aurocerasi	1 oz.
	Aqua dist.	6 oz.

At first one teaspoonful of this solution (containing: $\frac{1}{33}$ gr. sod. arseni.) is given in coffee thrice daily, after meals, and this quantity is gradually increased, as in the case of Fowler's solution.

3. As pills, the "Asiatic" pills have long been a favourite method in Germany and, especially, in Vienna.

R.	Arsenious acid	$\frac{3}{4}$ gr.
	Powdered black pepper ...	8 gr.
	Gum arabic	$1\frac{1}{2}$ gr.
	Aquae	q.s.

Divide into ten pills, of which each will contain $\frac{1}{13}$ gr. arsenious acid, and give one thrice daily after meals. Increase the dose by one pill every four or five days until 8–10 are being taken daily. The total number given should not exceed 400, and the treatment should be abandoned if the condition is not ameliorated after that quantity has been taken, or if toxic symptoms occur.

(*b*) *By subcutaneous injection.*—A more rapid effect is by this means produced. If an inorganic salt of arsenic is to be employed, the best solution is probably the liq. sodii arseniatis, which can be boiled and filtered. One injection of 3 minims daily is given at first, and the amount is gradually increased by 1 minim at a time until either the required effect is produced, or early symptoms of intoxication arise.

The organic preparations of arsenic have already been referred to. I have no personal experience of them in cases of psoriasis, but more than one observer has testified to their value in obstinate cases, especially when local treatment is ill tolerated.

Iodide of Potassium.—This drug has been extensively used, and with success; but ordinary doses usually have no appreciable influence on the eruption. With larger quantities good results are often obtainable, but, although doses of from 200 to 300 grains daily are frequently tolerated, it is certainly not worth while employing the drug except in certain cases. For the arthropathic variety of this disease it is of undoubted service, and is best given together with mercurial injections.

Although its action would not seem to be a local one, it would be interesting to try the effect of combining its internal administration with a local application of a hydrogen peroxide ointment, such as the following:—

H_2O_2 (20 vols.)	... 40 parts.
Vaseline	... 20 "
Lanoline	... 10 "
Bismuth oxychloride ...	... 1 "
Sublimate	... $\frac{1}{10}$ "

Thyroid Extract. In cases of myxœdema, the administration of thyroid extract produces a more or less pronounced desquamation of the skin. Observing this, Byrom Bramwell was led to try its effects in certain desquamative skin diseases, and he has published some remarkable results, in cases of psoriasis, from this mode of treatment.

Since he first drew attention to the drug, it has been given a thorough trial, both in England and on the Continent, by several dermatologists, without, however, very encouraging results. Thus Thilierge (Annales de Dermatologie et Syphilographie, 1895) has published detailed

observations on thyroid medication in eleven cases of psoriasis, and he concludes that it is "a remedy of desperation." He admits that, combined with local treatment, it usually hastens the cure, but considers that the drawbacks attendant on its use forbid it except in intractable cases. At the same time, after carefully considering the results of several observers, I am inclined to think that it probably has an almost specific action in a few examples of the disease.

Mercury. This drug has not received the attention it deserves in psoriasis. In those cases associated with joint changes (Le Psoriasis arthropathique) it is, in combination with potassium iodide, the recognized form of treatment, but it might with advantage be tried more extensively in ordinary cases. M. Brault (Annales de Dermatologie et Syphilographie, 1895) has used it with marked success in the form of injections, without any form of local treatment whatever, in undoubted cases of psoriasis.

Tartarated Antimony, as recommended by Sir Malcolm Morris, is apparently of service in the acute stages. Fifteen minims of the wine thrice daily should be given.

The other internal remedies, *e.g.*, turpentine, salicin, salicylates (Crocker), carbolic acid (Kaposi), and balsam of copaiba (Hardy), as has already been pointed out, are mostly of the nature of "internal antiseptics."

Such, then, is a short and disconnected review of the commoner methods of internal drug treatment. An entire lack of experience of most of them prevents me from advocating any one of them, but there can be no question that the present day tendency to rely almost completely upon external treatment is entirely justifiable. That it will remain so, however, is another question. For those who wish to combine the two, the arsenical treatment is probably the most reliable, although mercury, either by injections or by the mouth, will very likely prove a successful and agreeable alternative. And it should be remembered that there do exist cases which respond brilliantly to thyroid extract, and that the group of intestinal antiseptics, combined, perhaps, with a total change of diet, at least affords opportunity for experimental therapeutic research.

Local Treatment. In considering the question of local treatment, it is very important to realize that, before active remedies can be employed, it is sometimes necessary for the patient to undergo a preliminary preparation. For instance, if the eruption is very acute, irritated, or infected, the inflammation must be first subdued with soothing baths and ointments. For these cases mild alkaline or starch baths are the best. The addition of one or two ounces of sodium carbonate suffices for the former, and for the latter, one or two pounds of starch. As alternatives, bran (2–4 lbs.) or gelatine (1–2 lbs.) may be used. The patient should remain in the bath, which is kept at or a little above body temperature, for about half an hour, and immediately after drying, a soothing ointment or paste should be applied to the patches, and the whole body dusted with starch or zinc powder. As an ointment the following is good:—Zinc oxid. 3 dr., lanoline 1 dr., aq. calcis, ol. amygd. each 1 oz.; for a paste either Lassar's, or the pasta zinci mollis of Unna (calc. carbon. præc., zinc oxid. each 2 parts, ol. lini, aq. calcis, each 3 parts) may be employed. It is obvious that in these irritable cases the more active agents must be very tentatively and gradually brought into service, and it is better to begin with the milder remedies, such as resorcin, ichthyol, β naphthol, and salicylic acid, before one passes on to chrysarobin, pyrogallol, tar, etc.

In contrast to the above cases we have those in which the scales are abundant, thick, and adherent, and the first step in the treatment is to remove these. This may be effected in most cases by prolonged or frequent baths, preferably alkaline, combined with vigorous scrubbing with tar or salicylic acid soap. Sulphur baths (potassa sulphurata, ¼ oz. to each gallon of water) are very useful in very chronic or resistant eruptions, but they should not be too prolonged. In some places, especially on the knees and elbows, the scales sometimes form a veritable carapace, and for these salicylic acid is required. It may be applied as a 10–15 per cent. ointment, but far better as a collodion (acid. salicyl, anæsthesin, spirit. æther, each 10, collodion, ad 100), or as a 10 per cent. plaster. It is often difficult to rid the scalp of scales. They should first be softened with an ointment containing sulphur and salicylic acid (*e.g.*, sulphur præcip., 10 gr., acid. salicyl. 5 gr., vaseline, ½ oz.), and then the head should be thoroughly and frequently washed with a spirit soap (equal parts of sapo viridis and 95 per cent. spirit).

We now come to the all-important and much-vexed question of local curative treatment, and, at the outset, it may be remarked that success depends not on the exclusive use of this or that agent, but on the intelligent combination of many; and it is futile to follow any one method rigidly in every case with the hope of unvarying success.

The actual method to employ depends largely on whether or not the patient can submit himself entirely to his treatment. If this be possible, in private clinics, in hospitals, and in sufficiently convenient home surroundings, the chrysarobin-pyrogallol combination (Die grosse Kur der Psoriasis) is probably the best, and I will describe this first, according to an account of it by Unna and Mesian.

Unna and Golodetz have shown that, when applied to the skin, chrysarobin is oxidised to chrysophanic acid, and on this reaction would seem to depend its activity. They have also shown that oleic acid is concerned in this process, and the parts of the skin in which it is present in abundance are precisely those which are most sensitive to the influence of chrysarobin, whereas the elbows, the knees, the shanks, and the forearms, which are characterised by a deficiency in oleic acid, are very resistant. Because of its irritating properties chrysarobin is not applied to the most sensitive areas, or to the parts where it is likely to gain access to the eyes (*e.g.*, head and hands), since it may cause a most intense conjunctivitis. Therefore the face, head, neck, hands, and genitalia are treated with pyrogallol, and the use of chrysarobin is confined to the rest of the body. The limitation of pyrogallol to the parts mentioned precludes the possibility of general intoxication from its absorption, and chrysarobin, which is not a phenol, produces no poisoning effects. That it is not absorbed at all, however, as some state, does not seem to me to have been proved.

The compound ointments of Unna possess undoubted advantages, especially in the case of chrysarobin, which acts better in an ointment than in other media; the addition of ichthyol, moreover, considerably diminishes its irritating properties. The formulæ are as follows:—

R.	Chrysarobin	5 parts.	
	Ichthyol	5	"
	Acid. salicyl.	2	"
	Vaselin flav.	88	"

Fiat ungt.

R. Pyrogallol ... ... 5 parts.
Ichthyol... ... ... 5 „
Acid. salicyl. ... ... 2 „
Vaselin flav. ... ... 88 „
Fiat ungt.

Every morning and evening these ointments are carefully applied with a broad, flat paint brush, and the patient then dons special garments, as fat-proof as possible, preferably Jaeger combinations, and a woollen cap and stockings. According to its sensibility, on the second or third day the skin begins in parts to redden; when this erythema has increased somewhat, and is accompanied by some soreness, the reddened patches are covered with zinc, or zinc and sulphur paste, *e.g.*:—

R. Zinc oxide ... ... 24 parts.
Terr. silicene ... ... 4 „
Ol. benzoinat. ... ... 12 „
Adip. benz. ... ... 60 „
Fiat past

R. Zinc oxide ... ... 14 parts.
Sulph. præcip. ... ... 10 „
Terr. silicene ... ... 4 „
Ol. benzoinat. ... ... 12 „
Adip. benz. ... ... 60 „
Fiat past

but the more resistant parts are still further treated with chrysarobin.

At the end of five or six days almost the entire skin will, in this way, be covered with a mild paste, and then for the first time the patient can take a good bath, but he must be scrupulously careful that none of the chrysarobin-tainted water comes into contact with the eyes. Three-quarters of the eruption will now probably have been removed, but it is imperative the cure be a complete one; the remaining resistant patches, therefore, must receive further treatment, for, if left, they will very likely cause an early recurrence of the generalized eruption, and they themselves will become even more difficult to eradicate.

From my own experience I can say that this mode of treatment is very effective, but some patients, especially English ones, rebel against the bathless week, and it is only fair to mention an alternative method of using chrysarobin. The following is taken from the writings of Audry. He recommends this prescription:—

R. Chrysarobin ... ... 5–7 parts.
Paraffin wax ... ... 40 „
Anhydrous lanoline ... 40 „
Olive oil ... ... 30 „

At the beginning of the treatment the ointment is only applied during the night. In the morning a bath is taken (preferably containing starch or bran, and as prolonged as possible), and a simple zinc ointment (*e.g.*, equal parts of oxide of zinc, lanoline, and vaseline) used for the daytime. After a short time the chrysarobin is applied for longer periods, according to the tolerance of the skin.

Of course, Unna's compound ointment can be used in the same way, and the method is suitable for the treatment of patients in their own homes, when the facilities that a private clinic or a hospital afford are necessarily wanting. Under these circumstances, instead of the pyrogallol, white precipitate ointment may be conveniently used for the hands and head, *e.g.*,

R. Ung. præcip. alb. ... 30 parts.
Acid. salicyl. ... ... 1 „
Mix.

This milder method, of course, takes longer than the other, and in some cases may with advantage be combined with the internal administration of arsenic. And even with the first-mentiond, arsenic is useful when the nails are affected.

In lower-class practice, when close supervision is impossible and care and intelligence cannot be expected, chrysarobin and pyrogallol are best avoided. The same applies to Out-Patient Clinics in which the patients are only seen once or twice a week. In these cases tar is probably the best substitute, and is very extensively and successfully used. In France the oil of cade treatment has become almost classical; in England coal tar is usually employed in preference to the wood tars, the liquor carbonis detergens, and the liquor picis carbonis being standard preparations.

The following is a résumé of the oil of cade method, as recommended by Brocq, "for a patient with an extensive eruption, who cannot remain under the close supervision of a doctor, but can without difficulty carry out the treatment himself."

1. The scales are removed by sulphur or alkaline baths in which the patient rubs the patches vigorously with tar or salicylic acid soap, and during the treatment a bath may be taken every day. Cade baths are useful, and are made as follows: To the yolk of an egg is added slowly from 1-2 oz. of oleum cadinum, with the requisite quantity of extract of quillaia, and about 8 oz. distilled water. This mixture is thoroughly stirred and emptied into an ordinary bath.

2. Immediately after the daily bath, as well as morning and evening when possible, the following preparation is rubbed into the patches, as vigorously as the tolerance of the patient's skin allows:—

R. Oil of cade ... ... 50–100 parts.
Glycerole of starch ... 90 „
Salicylic acid ... ... 3 „
Soft soap, q.s. (to emulsify the oil).
Oil of cloves, q.s. (to mask the smell of the cade).

Or

R. Oil of cade ... ... 40 parts.
Paraffin wax ... ... 10 „

The latter is easier to manipulate.

3. As with the chrysarobin-pyrogallol method, special garments are then worn, and, since they become impregnated with the cade oil at the site of the psoriatic plaques, they form a kind of continuous medicated bath.

4. If the patient must continue to pursue his normal life, the cade should be applied before going to bed, and the special garment worn only during the night. In the morning the skin is washed with hot water and a perfumed soap, and an odourless ointment containing salicylic acid used during the day.

5. It must not be forgotten that oil of cade may produce an acneiform folliculitis. Should this occur, the treatment must be suspended, and soothing baths and ointments be employed until the inflammation has subsided; thereupon the cade may be reapplied, at first, however, in weak preparations.

Very similar to this method of tar treatment is that recommended by Unna and Mesian. The following ointment is prescribed:—

R. Vitelli ovi ... ... 40 parts.
Vaselin ... ... 60 „
Picis liquid. ... ... 20 „
Mix.

Every evening the patient washes the whole body with soap and hot water, and the addition of salt to the latter will help to soften the horny layer of the skin. The ointment is then applied to the whole body. In the morning only the hands and face are washed. If, however, this method is employed with patients who can remain at home or in a hospital, a morning application of the ointment is also made.

A general outline of two of the chief methods of treatment has now been given, but it is necessary to consider certain modifications, which may well be made under certain circumstances. Thus, when dealing with chronic or obstinate patches, which are especially liable to occur on the knees and elbows where the horny layer of the skin is thick, chrysarobin and pyrogallol may be conveniently prescribed in a collodion or varnish. A very effective preparation may be made by combining two parts of one of these substances with twenty parts of the salicylic collodion, the formula of which has already been given. Traumaticin is another useful vehicle, and I have seen an extensive eruption cleared on a girl of fourteen, who was treated as an out-patient, by the daily application first of chrysarobin-traumaticin (1 : 10), and later of pyrogallol-traumaticin, the patient taking a bath every three or four days. With pyrogallol, of course, symptoms of intoxication must be looked for.

These collodion or varnish combinations are cleanly, and are often of value in private practice, more especially when the patches are few, since they allow the patient to go about with a minimum of inconvenience. In the same way, Dremo's well-known ointment is useful and effective in such cases:—

R. Chrysarobin ... ... 20 parts.
Ol. rusci ... ... 20 „
Acid. salicyl. ... ... 10 „
Sapo virid... ... ... 25 „
Vaselin ... ... 25 „
Mix.

The tar in this preparation keeps the chrysarobin strictly confined to the patches, and thereby prevents the customary surrounding irritation; on the other hand, after some days of treatment black crusts form at the points of application, and take some time to separate off. Another very good formula for ambulatory and rebellious cases is the following:—

R. Acid. salicyl. ... ... 1 part.
Acid. pyrogall ... ... 4 parts.
Ichthyol ... ... 10 „
Picis liquid. ... ... 10 „
Sapo virid. ... ... 2 „
Lanolin ... ... 10 „
Vaselin ... ... 30 „

to which may be added, when desired, chrysarobin 1–3 parts.

When the hands are badly affected it is advisable to envelop them in an impermeable dressing, *e.g.*, guttapercha or indiarubber gloves or fingerstalls may be worn. Chrysarobin and pyrogallol stain the nails, and tar and salicylic acid are preferable in better-class practice. If the nails themselves are affected, arsenic should be given internally, as recommended by Sir Jonathan Hutchinson, and the X-rays form a very convenient and effectual method of local treatment.

An efficient prophylactic and curative treatment of the scalp is of the very greatest importance. As already stated, the scales can be removed by frequent washings with spirit soap, and applications containing salicylic acid and sulphur. For the further treatment pyrogallol is undoubtedly very efficacious, but it must not be used for fair-haired persons, because of its darkening properties, and even with brunettes it tends to produce a reddish-brown tint—to my mind rather attractive—which may cause offence. As a substitute, mercurials are good. White precipitate, or yellow oxide ointments, or the ung. hydrarg. ammon. may be employed, and the addition of liq. picis carbonis and salicylic acid (a drachm and fifteen grains to the ounce respectively) increases their effectiveness. The following combination of sulphur, salicylic acid, and tar is a favourite pomade of Sabourand:—

R. Ol. cadini ... ... 10 parts.
Ol. rusci ... ... 1 part.
Sulphur præcip., resorcini, acid. pyrogallic. each ½–1 „
Cocoa butter ... ... 5–10 parts.
Vaselin ... ... 20 „
Mix.

Although the value of X-ray treatment is generally admitted, it is seldom employed except for scanty eruptions, or for old and resistant patches. But, as Unna and Mesian point out, its use is not necessarily confined to such cases, for "all parts of the skin from the head to the sole of the foot can by successive exposures be treated in the course of a few hours." They recommend that three small doses (one-third Sabourand pastille) should be given: the second eight days after the first, the third fourteen days after the second.

My own experience of the treatment is limited to cases in which it has been used for the last remnants of an eruption, and for these it is certainly very satisfactory. The method is an attractive one on account of its simplicity and cleanliness; and the objection often made, that it may result in scars and telangiectases appearing at the sites of exposure, is probably groundless, if the doses mentioned are employed with reasonable care. At the same time the regulation of the dosage is often difficult, depending as it does on the part of the skin under treatment and the character of the patches. The general tendency, therefore, is to employ the method only as an adjunct to the more usual forms of treatment.

Lastly, we come to the all-important consideration of the *after-cure*, and the prophylaxis of the disease. Every psoriasis patient who undertakes to submit himself to thorough treatment, should be warned of the necessity for the absolute removal of every vestige of the disease. Incidentally, it is by no means easy to determine when this result is attained, and very careful inspection is required, the parts to which attention should be chiefly directed being the extensor aspects of the limbs and the scalp. The importance that Unna and Norman Walker attach to the part played by the latter in the origin and spread of certain skin diseases, including psoriasis, is, I am sure, in no way exaggerated. Personally, I believe that quite half the practice of many dermatologists and cosmetic specialists would disappear if everyone were compelled by law from early childhood to wash

the scalp every week with spirit-soap, and to use a mildly antiseptic lotion, containing a certain quantity of oil or glycerine every day.

Such a Utopian scheme, however, is probably impracticable, and so the aforesaid dermatologists and beauty specialists may live in comfort and peace of mind.

But to return to psoriasis,—the last traces from the body may be conveniently removed by chrysarobin or pryogallol in collodion or plasters, or by Dremo's ointment, and from the head by a combination of white precipitate ointment, tar, and salicylic acid, *e.g.*,

R. Ung. præc. albi, ung. helvæ, ung. picis... ... each 15 parts.
Acidi salicylici, ol. citronellæ ... .. each 1 part.
F.M.

When at last no further trace of the disease can be found, the danger of recurrence must be made quite clear to the patient. He should, if possible, submit himself for inspection at first once a week, and later once a fortnight. In addition he should wash himself every day with a mild, super-fatted soap, and afterwards, if he can be so persuaded, annoint his skin with an invisible 1 per cent. resorcin vaseline. The occasional use of tar baths, *e.g.*, oil of cade, is also advisable.

The slightest sign of recurrence calls for immediate and vigorous treatment with strong chrysarobin and pyrogallol applications. Above all should attention to the scalp be insisted upon; it should be washed at least once a week with spirit-soap (equal parts of sapo mollis and spirit 95 per cent.), and a lotion containing resorcin and castor oil applied every day. If oil is objected to, glycerine may replace it, as in the following :—

R.	Hydrarg. perchlor.	2 gr.
	Ammon. chlorid.	10 gr.
	Resorcin	1 dr.
	Eau de Cologne	2 oz.
	Glycerine	2 dr.
	Aq. rosæ ad.	8 oz.
F.M.		(Sequeira.)

The use of a pomade, well rubbed into the scalp once or twice a week at night-time, is of additional service, and I can vouch for the value of this prescription:—

R.	Acidi salicylici	10 gr.
	Sulph. præcip.	15 gr.
	Tinct. cantharid.	20 m.
	Balsam. peruv.	50 m.
	Adip. colli equin ad.	1 oz.
F.M.		

Such, then, are some of the present-day ideas on the treatment of psoriasis, and it is to be hoped that they will soon be replaced by others. For the fight against a severe attack is a most unpleasant one for the patient, and usually productive of very little credit for his medical man. New applications are, of course, constantly being tried, the one of which I have most knowledge being ichthargan, a compound of ichthyol and silver. One of its advantages is that is enables one to detect the last traces of the eruption. I hope later to give an account of some results from its use both in psoriasis and other diseases.

Believing, as I do, that in psoriasis two factors are concerned—*an external parasitic and an internal toxæmic*, perhaps also of parasitic origin—future advances in its treatment will probably, I think, be on internal and not external lines. For by local treatment we probably destroy the external parasite, and perhaps also, through the absorption of the drugs used, diminish the activity of the internal organisms, if such there be, or, at any rate, neutralise to some extent the toxæmia. But in most cases the latter continues, or reasserts itself after an interval, and if the external parasite be again available, the necessary conditions for its spread are satisfied, and another eruption results. The effect of prophylactic hygienic measures is, of course, probably merely an antiseptic one.

Appointments.

Naval and Military.

Lieut.-Colonel G. T. Rawnsley, R.A.M.C., has been appointed Deputy Assistant Director of Medical Services to the East Lancashire Division.

Captain W. H. S. Burney, R.A.M.C., has been appointed to hold Medical Charge, Military Hospital, Attock, Punjab.

Captain A. C. H. Gray, R.A.M.C., has been appointed Adjutant and Instructor to Royal College of Surgeons (Ireland) Contingent, O.T.C., R.A.M.C.

Civil.

Chapple, H., M.C., F.R.C.S., has been appointed Obstetric Surgeon, Guy's Hospital.

Depree, H. T., M.B., B.C., has been appointed Honorary Anæsthetist, Guy's Hospital.

Digby, Kenelm H., M.B., B.S., F.R.C.S., has been appointed Professor of Anatomy, the University of Hong Kong.

Fawcett, John, M.D., F.R.C.P., has been appointed Physician to Guy's Hospital.

Hunt, G., M.B., B.Ch. Oxon., M.R.C.P., has been appointed Fifth Assistant Physician, Guy's Hospital.

Isaacs, D., M.R.C.S., L.R.C.P., has been appointed Assistant Medical Officer, Shoreditch Infirmary.

Trethowan, W. H., M.B., B.S., F.R.C.S., has been appointed Orthopædic Surgeon, Guy's Hospital.

Lancaster, H. F., M.D. Brux., M.R.C.S., L.R.C.P., has been appointed Consulting anæsthetist, Guy's Hospital.

Royal College of Surgeons of England.

The following has been elected a member of the Council, Royal College of Surgeons :—

L. A. Dunn, M.S., F.R.C.S.

Honours.

The King has given permission to Captain R. G. Anderson, R.A.M.C., to accept and wear the Decoration of the Fourth Class of the Imperial Ottoman Order of the Medjidieh which has been conferred on him by the Khedive of Egypt, in recognition of various services rendered by him.

The President of the Residents.

Pass List.

University of Cambridge.

EXAMINATIONS FOR MEDICAL AND SURGICAL DEGREES.—EASTER TERM, 1913.

SECOND EXAMINATION.—(New Regulations.)

Part II.—Pharmacology and General Pathology.

Examined and approved.

P. R. Boswell. | E. C. W. Starling.

THIRD EXAMINATION.—(New Regulations.)

Part I.—Surgery and Midwifery.

E. S. Taylor.

Part II.

E. S. Taylor.

(Old Regulations.)

Part I.—Pharmacology and General Pathology.

A. S. Seabrooke. | J. Ll. M. Symns.

Part II.—Surgery, Midwifery, and Medicine.

Examined and approved.

The following have now satisfied the Examiners in all three sections:—

V. F. Soothill. | J. Ll. M. Symns.

University of Durham.

The following Degrees were conferred in June:—

M.B.

Jap-ah-Chit. | G. E. W. Lacey.

B.S.

Jap-ah-Chit. | G. E. W. Lacey.

Pass List.

Third Examination for Degree of M.B.

H. H. Elliot. | P. Savage.

(Materia Medica, Pharmacology, and Pharmacy, Public Health, Medical Jurisprudence, Pathology, and Elementary Biology.)

H. V. Leigh.

(Public Health, Medical Jurisprudence, Pathology, and Elementary Biology.)

First Examination.—Elementary Anatomy and Biology.

M. C. Joynt. | H. Sterne-Howitt.

University of Oxford.

The following Degree has been conferred:—

B.M.

F. A. Hampton. | W. H. Ogilvie.

Papers by Guy's Men.

David Forsyth, M.D., D.Sc., F.R.C.P.: On Psycho-Analysis. The substance of two lectures delivered at the Polyclinic, London.—*British Medical Journal*, 5th July, 1913.

E. W. H. Shenton, M.R.C.S., L.R.C.P.: Elimination of Errors in the X-ray Diagnosis of Urinary Calculus.—*Lancet*, 12th July, 1913.

A. H. Tubby, M.S., F.R.C.S.: Orthopædic Surgery.—*Practitioner*, July, 1913.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—ED., G.H.G.]

DEAR SIR,—I have just had a case of cervical herpes in a woman of 40, followed by chicken-pox in her only child of five, fifteen days after the onset. The mother had pyrexia throughout this time, 100°—102°. I warned her of the possibilities which developed.—Yours truly.

T. L. JACKSON.

Holly House,
Cheadle, Cheshire.
July 4th, 1913.

Nursing Notes.

"NURSING TIMES" LAWN TENNIS CHALLENGE CUP.

GUY'S v. NORTH EASTERN HOSPITAL.

Our team won this tie easily, the scores being:—

"A" TEAM.

Sisters Hickman and Stewart 6–2, 6–2

"B" TEAM.

Nurses Rowan and Ryan 6–2, 6–1, 6–0

SEMI-FINAL ROUND.

GUY'S (Holders) v. ST. GEORGE'S.

This tie was very keenly contested, but resulted finally in a win for Guy's by the narrow margin of 31 games to 28.

Guy's meet Queen Mary's Hospital (Carshalton) in the final.

Notices.

University of Cambridge.

FIRST EXAMINATION FOR MEDICAL AND SURGICAL DEGREES.—OCTOBER, 1913.

PLAN OF EXAMINATION (subject to alteration in details, of which due notice will be given).

Part I. (Chemistry).

Friday, October 3. 1.30 to 4.30 p.m. Chemistry (in the Senate House.

Saturday, October 4. 2 to 5 p.m. Practical Chemistry and Oral Examination in Chemistry (in the University Laboratory).

Part II. (Physics.)

Friday, October 3. 10 a.m. to 12 m. Mechanics, Hydrostatics, and Heat (in the Senate House).

Saturday, October 4. 10 a.m. to 12 m. Electricity and Optics (in the Senate House).

Monday, October 6. 10 a.m. to 4 p.m. Practical Physics and Oral (in the Cavendish Laboratory).

Tuesday, October 7. 10 a.m. Practical Physics and Oral (continued if required).

Part III. (Elementary Biology.)

Monday, October 6. 1.30 to 4.30 p.m. Elementary Biology (in the Senate House).

Wednesday, October 8. 9 a.m. to 12 m. Oral and Practical Examination in Elementary Biology (in the Biological Laboratory).

The names of candidates for this Examination must be sent to the Registrary (through the Praelectors of their respective Colleges) on or before Friday, 12th September.

It is requested that the names may be written on the Forms sent to the Praelectors.

Any candidate whose name has not been sent in before Tuesday, 23rd September, is required to pay an additional fee of £1 if he be nevertheless admitted to the Examination.

Registry, 28th June, 1913.

SECOND EXAMINATION FOR MEDICAL AND SURGICAL DEGREES.—OCTOBER, 1913.

Part II. (Pharmacology and General Pathology.)

ORDER OF EXAMINATION (subject to alteration in details, of which due notice will be given).

Wednesday, Thursday and Friday, October 1, 2 and 3. 9.30 a.m. and 2.30 p.m. Oral and Practical Examinations in Pharmacology and in General Pathology (in the Medical Schools.

The names of candidates for this Examination must be sent to the Registrary (through the Praelectors of their respective Colleges) on or before Wednesday, 10th September.

It is requested that the names may be written on the Forms sent to the Praelectors.

Any candidate whose name has not been sent in, and whose Certificates have not been received on Saturday, 20th September, is required to pay an additional fee of £1 if he be nevertheless admitted to the Examination.

Registry, 28th June, 1913.

Guy's Hospital.

The following appointments have been made:—

Dental Anæsthetist, in the place of Dr. Lancaster, retired.—Mr. H. T. Depree.

Senior Medical Radiographer.—Mr. J. Lindsay Locke, M.B., Ch.B. Ed.

Lecturer in Pharmacology.—Mr. A. J. Clark, M.B. Cantab., M.R.C.P. Lond.

Lecturer in Medicine.—Dr. Fawcett.

Demonstrator in charge of Revision Classes in Midwifery and Diseases of Women.—Mr. Chapple.

Curator of Gordon Museum.—Mr. Davies-Colley.

Pathologist.—Dr. Cameron.

Demonstrator of Medical Pathology.—Dr. Hunt.

July 7th, 1913.

Royal College of Surgeons of England.

LICENCE IN DENTAL SURGERY.

Notice is hereby given that every Student who commences recognised Professional Study on or after the 1st October, 1913, will be required to pass the Preliminary Science Examination, or some other Examination recognised as equivalent thereto, before attending the courses of study laid down in the Regulations for the Second Professional Examination.

S. FORREST COWELL, Secretary.

12th December, 1912.

Cricket.

GUY'S v. GRANVILLE.

Played at Lee, Wednesday, July 2nd. This match, after an enjoyable game, ended in a defeat by six wickets. C. L. Curle, scored a maiden century, the first, we hope, of many. Our bowlers were considerably handicapped by the rain.

GUY'S.

A. B. Bond, b Wood	77
A. C. Hancock, b Wood	8
C. L. Curle, b Brown	110
L. H. Dixon, c Ford, b Wood	5
C. Vincent-Brown, lbw, b Wood	10
A. H. Harkness, b Brown	5
C. Pearson, c Odell, b Wood	12
H. Sheldon, c Platt, b Wood	8
F. Biddle, not out	6
H. Hubbard, c Anderson, b Wood	0
R. V. Cookes, b Wood	0
Extras	22
Total	263

GRANVILLE.

S. Platt, b Dixon	3
W. Cockell, c Hubbard, b Dixon	17
J. Russel, b Sheldon	58
C. R. Brown, b Harkness	128
F. Odell, not out	34
L. Wood, not out	12
Extras	21
Total (for 4 wickets)	273

GUY'S v. FOREST HILL.

Played at Forest Hill on Monday, July 7th. This, the last match of the season, was abandoned owing to rain. Dixon played a really good innings.

GUY'S.

A. C. Hancock, c Skerratt, b Betham	5
A. B. Bond, b Matthews	1
C. L. Curle, b Betham	0
C. Vincent-Brown, b Matthews	0
L. H. Dixon, not out	48
G. W. M. Andrew, c Moore, b Matthews	5
A. H. Harkness, b Betham	20
L. R. Broster, not out	10
Extras	17
Total (for 6 wickets)	106

Shooting.

This year has again proved unsatisfactory as regards the Inter-Hospital Competitions. Guy's obtain the Armitage Cup owing to the inability of St. Bart.'s and other hospitals to raise a team on two out of the three dates arranged.

The United Hospitals Cup at Bisley, which was last held by Guy's, will be shot for on Thursday, July 17th, when representative teams from Guy's, St. Bart.'s and Charing Cross will compete.

Our President, Mr. R. Thompson, was good enough to bring a team against us and this year we were defeated. The scores were:—

GUY'S.	
H. Hogben	91
E. J. Cooke	73
J. T. Forbes	92
F. D. Annesley	70
G. W. Elkington	83
P. Platts	79
	488
The Presidents	504

Individually members of the Guy's VI. have shot well.

H. Hogben, of the Irish XX., has won the Championship of the University of London, and in the Imperial Universities' Match $\frac{100}{105}$ at 300, 500, and 600 yards, and $\frac{83}{105}$ at 800, 900, and 1,000. He has also made a seven shot possible at 1,000 yards.

S. E. Johnson shot in the London and Middlesex Counties Rifle Association Team, which beat Australia. In the Imperial Universities Match he scored 98 at the short ranges and 90 at the long; while he was also successful in the Scottish Championship.

The Annual Prize Meeting was held at Bisley on Wednesday, June 25th.

We should like to take this opportunity of thanking our many friends for their kindness, as it is their assistance which enables us to hold a successful meeting.

Our best thanks are due to A. P. Beddard, Esq., M.D., and R. P. Rowlands, Esq., M.S., and Messrs. Ash & Co., Ltd., Down Bros., Ltd., H. H. Grattan, The Holborn Surgical Instrument Co., and Messrs. Claudius Ash & Sons.

It is worthy of note that four out of the five competitions, including the aggregate, were won with the new Club Rifle, which has just been given us by the Clubs' Union. Results:—

1. NEWTON PITT CHALLENGE CUP.

H. Hogben	93
E. J. Cooke	90
S. E. Johnson	90

2. HANDICAP COMPETITION, 7 shots at 200, 500, and 600 yards.

G. W. Elkington	85	10	95
H. Hogben	93	scr.	93
E. J. Cooke	90	scr.	90
S. E. Johnson	90	scr.	90
L. D. Wright	85	5	90
C. H. Laver	68	20	88
J. T. Forbes	78	5	83
F. D. Annesley	68	10	78

3. 600 YARDS COMPETITION.

F. D. Annesley	46
E. J. Cooke	45
H. Hogben	44

4. 1,000 YARDS COMPETITION.

E. J. Cooke	41
F. D. Annesley	38
H. Hogben	37

5. AGGREGATE.

E. J. Cooke (1), H. Hogben (3), S. E. Johnson (4).

Golf.

GUY'S v. LONDON.

INTER-HOSPITAL CUP TIE, FIRST ROUND.—RE-PLAY.

This match was played at Sundridge Park on Wednesday, July 2nd, and resulted in a victory for Guy's after an exciting match by 5 matches to 4.

J. F. Venables made a great effort towards our victory, as he was 4 down and 6 to play and eventually won his match on the last green.

Guy's now meet St. Thomas's (the holders) in the next round, and we shall all have to be on top of our game to have a chance of reaching the final. Scores:—

GUY'S.		LONDON.	
L. A. Graham	0	L. C. Somervell (8 & 6)	1
R. Curle	0	J. Deignton (3 & 1)	1
J. T. T. Forbes	0	L. K. Tweedie (6 & 5)	1
A. C. M. Coxon (3 & 2)	1	A. G. Hardwicke	0
J. F. Venables (1 up)	1	G. V. Bakewell	0
F. A. Knott (2 & 1)	1	J. S. Jobson	0
C. Lambrinudi (8 & 7)	1	A. E. Herman	0
W. E. Tanner	0	W. S. Herman (3 & 2)	1
G. Noott (2 & 1)	1	H. Whyte	0
	5		4

PAPERS RECEIVED.—The Hospital, The Nursing Times, The Prescriber, St. Bartholomew's Hospital Journal, The Stethoscope, Clinical Journal, St. George's Hospital Gazette, Polyclinic.

Births.

EVANS.—On July 3rd, at Floriana, Malta, the wife of Major C. R. Evans, R.A.M.C., of a son.

MORGAN.—On Monday, June 30th, 1913, at Groombridge, Sketty, R.S.O., Glam., the wife of Dr. Edward (Teddy) Morgan, of a daughter.

Marriage.

BRANGWIN—SWANN.—On 5th April, 1913, at St. John's Cathedral, Hong Kong, by the Right Rev. G. H. Lander, D.D., Bishop of Victoria, Hong Kong, Charles Harold Brangwin, Customs' Medical Officer, Swatow, China, to Dorothy Alice, eldest daughter of Nathaniel Swann, of Yarmouth, Norfolk, England.

G. T. M.

GUY'S HOSPITAL GAZETTE.

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Passim.

WE congratulate Bart.'s on the honour conferred upon one of her alumni, and thus indirectly upon herself, by the appointment of Mr. Robert Bridges as Poet Laureate. Mr. Bridges' connection with medicine is far closer than that of our own poet Keats. He not only qualified, but was actually in practice for years at Great Ormond Street and at the Great Northern Hospital.

The list of medical poets is a very short one, and one wonders how many additions there are likely to be to the list in future. It is easy to understand the association of the poetic temperament with medicine in the days when the latter calling was an Art, but in this ultra-scientific age the imagination cannot so easily conceive a temperament which would be happy both as poet and as doctor. And in this connection one notes with interest that Mr. Bridges retired from practice in 1882, when one supposes the modern era of medicine was beginning.

WE much regret to have to chronicle the retirement, under the age limit, of Dr. H. F. Lancaster, which took place on July 31st. Dr. Lancaster has been Honorary Anæsthetist to the Hospital since 1893. He is a Guy's man, having entered in 1872, and qualified in 1875. After qualifying he was in turn H.P., H.S., and Obstetric Resident. We wish him many more years of happiness and usefulness.

WE were privileged to participate in a sorrowful, but interesting ceremony in the Surgeons' Room on Tuesday last. The occasion was a presentation to Sister Luke (Miss A. N. Cross), on her resignation, from her surgeons and dressers, headed by Mr. Golding-Bird, Mr. Dunn, and Sir Alfred Fripp. Sister Luke retires after twenty years active and devoted work in the hospital. She entered in 1893 as a "Lady Pupil," and was made Sister in 1894. She was first in charge of Lazarus, and a few years later came up to Luke. Mr. Golding-Bird, who presented the gifts, made a very neat and appropriate speech, and was seconded by Sir Alfred Fripp. Sister looked, we believed, more worried than ever an erring dresser could have made her. The presentation consisted of a silver rose-bowl, and an album containing the signatures of many old dressers. Miss Cross carries with her the good wishes and regrets of all who have worked in her ward.

WE would direct the attention of our readers particularly to an appeal from Mr. Wingent, the Honorary Curator of the Gazette Museum of Guy's Antiquities, which appears in this issue. Mr. Wingent gives an account of the objects of the museum and of its housing, but characteris-

tically he omits to mention that the new institution owes its inception and successful inauguration to his efforts. The fact that Mr. Wingent, whose interest in and knowledge of the past of our hospital is almost unrivalled, is in charge of the museum is, we hope, a sufficient guarantee that all the objects which are at present in his possession, and any which may be obtained in the future, will receive that loving care which is their due. It is earnestly to be hoped, therefore, that any Guy's men who have objects of interest, falling within the scope of the museum as outlined by Mr. Wingent, will not hesitate to present them now or at some later date.

THE white slips, used in the Surgery for doubtful cases which are being kept under observation, are not satisfactory in that they are made of a thin fragile paper which is not made to stand the wear and tear of a Borough mother's pocket. The state into which these papers get after one or two visits is better imagined than described. They are usually produced black and greasy and falling to pieces, either from a grimy pocket or from the still more grimy paws of the inevitable child. We understand, of course, that nothing short of a metal tablet would ever reach the ideal, but at the same time if the slips were of cardboard, or at any rate of stout paper, and had the printed notice across the top instead of in the middle as at present, they would be a distinct improvement. Nowadays it is often quite impossible to decipher what was written on the paper twenty-four hours previously.

WE are informed that the Bulgarian Government is anxious to engage five fully-qualified men to act as surgeons in the present war. The salary offered is 600 francs per months. Any further information may be obtained from the Bulgarian Legation, 51, Queen's Gate, S.W. Application should be made without delay. The travelling expenses of the selected men will be paid by the Balkan War Relief Fund.

WE noted, with interest, the announcement in the daily papers some days ago, that under the will of Mr. Alfred King, of Worthing, the reversion of a property, estimated to be worth about £60,000, has been left to the Hospital for its general purposes.

THE "Going-off" Dinner was held on Thursday, July 31st, in the College Dining-room, and was, as usual, a very merry affair. The off-going Residents were Messrs. V. R. Glendining (President), G. T. Foster-Smith, A. C. Jepson, P. Smith, and A. H. Todd. The newcomers to the table are Messrs. G. S. Miller (Sir A. Lane), J. M. Joly (Mr. Dunn), T. I. Bennett (Dr. Pitt), T. P. Cole (Dr. Shaw), and H. C. Rook (Ophthalmic H.S.). Messrs. C. A. R. Gatley and L. Milton were elected President and Vice-President respectively for the coming three months.

CONGRATULATIONS to Mr. T. D. M. Stout on his success in the recent examination for the M.S. (London), and to Mr. Neville Cox for his success in the M.D. (London).

THE Treasurer's Gold Medal in Clinical Medicine has been awarded to Mr. A. H. Gould, and the Gold Medal in Clinical Surgery to Mr. J. F. G. Richards. We heartily congratulate both gentlemen.

MR. H. L. JAMES has been appointed obstetric Resident, his duties to commence on September 1st next.

THE Take-in H. S. recently received the following letter:—

"To the Surgeon,
Guy's Hospital.

Sir,

Would you kindly inform me what to do in the matter as under?

My father has had gangrene in one of his legs, and the Dr. has just been able to take away the portion of the leg and foot that is quite dead, we are uncertain what to do with the part taken off, whether it is lawful to bury it in the garden, or how to dispose of it.

I should be obliged if you could help me.

Truly yours,
——— ———."

Comment is superfluous, but all the same one would like to know what the H. S. said. It has been suggested that the problem would make a suitable "silly season" topic for the GAZETTE.

From the Ear and Throat Out-Patient Department.

By W. M. MOLLISON.

Case 1.—A Case of Tuberculous Ulceration of Nose, Pharynx, and Larynx.

Michael T., aged 39, a hawker by trade, attended in the Out-Patient Department in April, 1913, complaining of great pain on swallowing. He had had a cough for at least two years; during this time he had treated himself by sucking some tablets reputed to be a cure for all coughs, asthma, etc. Previous to these two years he had medical advice; this had been followed to some extent for the patient stated that he always took care to expectorate into the fire or out of the window!

The man was very pigmented and marked with pitted scars of variola; he was very thin and in spite of the pigmentation looked ill; his temperature was 102·0° F. Dr. French reported that there was extensive active phthisis at both apices and in the right lower lobe.

The great interest of the case lay in the multiple tuberculous ulcers of the upper respiratory tract. On the right ala of the nose was an ulcer about 12 mm. long and 5 mm. broad; it was pale and showed no tendency to bleed; it was very painful; the patient said it had begun as a pimple two months before. On the posterior pharyngeal wall there were three ulcers; these ulcers were quite small, not more than 3 mm. in a vertical direction and 1½ mm. in a transverse direction; they were surrounded by a slightly-raised edge, while on the floor was a white layer of mucus; they were at the level of the soft palate.

The epiglottis was pale and swollen and exhibited on its laryngeal aspect a fissured ulcer. The larynx was extensively ulcerated, especially so on the false cords, the right arytenoid was swollen.

The interest of the case lies mainly in the pharyngeal ulceration, this part of the upper respiratory tract is the least often affected and almost invariably in the latest stages of phthisis.

Treatment was directed to relieving the pain on swallowing; orthoform was dusted on to the pharyngeal ulcers and into the larynx, and orthoform pastilles given. Seen two days later the man said he could swallow well and was more comfortable than he had been for weeks.

Case 2.—A Case of Functional Aphonia in a Man of 58.

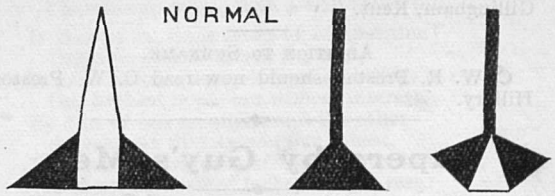
Wm. Y., aged 58, was sent by Dr. Vandermin, to the Medical Out-Patient Department, suffering from a cough and loss of voice for ten days. Dr. Fawcett examined the chest and found no abnormality, also X-ray examination showed nothing pathological. The man was transferred to the Ear and Throat Department.

The man was by trade a tunneller, and was engaged in making a tunnel through clay; the loss of voice had come on ten days previously quite suddenly; the patient only spoke in a whisper, though he could and did cough quite well; on being questioned he related that some years previously he had had a similar attack at a time when he was employed in a tunnel; also, as it happened, going through clay. He was a healthy looking man and said he felt well, his appetite was good and he had no difficulty in swallowing.

On examination of the larynx it was seen that the cords were normal in colour and form, and moved well on respiration; but on attempted phonation they did not come together, but a small triangular space was left posteriorly between the arytenoids. This condition is typical of functional affections of the larynx and the diagnosis of functional aphonia was made. The patient was re-assured that he would get well, and some strychnine prescribed, and Dr. Vandermin reports that the man is now practically well again.

The diagnosis between a functional and organic-nervous lesion of the vocal cords is, of course, a matter of great importance, particularly in a man of 58, like this patient; fortunately, this is usually a fairly simple matter, because it has been established* that in organic affections of the recurrent laryngeal nerve the fibres controlling the abductor muscles are those first affected, whereas in functional affections the adductor muscles are those affected. It will be remembered that the crico-arytenoideus posticus is the abductor muscle of the vocal cord, and in consequence organic disease gives rise to paralysis of this muscle, hence the term posticus paralysis is often given to these cases.

It is to be noted that in this patient the cords moved well in respiration, that is the abductors were sound; but when phonation was attempted, that is when adduction was required, the muscles failed. An additional point may be noted, only some of the adductor muscles failed in this case, namely, those which bring the arytenoids together, so that the anterior parts of the cords came together while the interarytenoid space remained open.



Inspiration. Phonation. Phonation in the case of Wm. Y.

Case 3.—A Case of Exudative Catarrh of the Middle Ear.

Eliza H., 21, was sent to the Ear and Throat Department by Dr. J. D. Thomas. The patient had been deaf in the left ear for years; the right ear had become deaf recently, since she had had sore throat.

On examination of the right ear the tympanic membrane was seen to be a little bulging outwards, to have a slightly yellow-pink tinge, and minute vessels were

* Semon's Law.

to be seen radiating from the malleus handle to the periphery; further, there was to be seen a black line concave upwards, about half-way up the membrane, and in front of the malleus; and this line remained, more or less, horizontal in spite of movements of the patient's head, thus suggesting there was fluid in the tympanum, and the black concave line was the upper limit of that fluid. An incision was made into the membrane in a vertical direction in front of the malleus, and a drop or two of serous fluid escaped. This incision did not cause pain. A Eustachian catheter was passed and the tube blown through, and a gauge drain inserted into the meatus. The girl was seen a few days later, and was found to have quite recovered her hearing in the right ear.

There is an excellent account of this condition to be found in the Guy's Reports, vol. xiv., third series, 1868, under the title "On Accumulation of Mucus with the Tympanum, and its Treatment by Incision of the Membrane Tympanic." by James Hinton. One cannot now, nearly 45 years later, add anything to Hinton's excellent paper.

Change of Address.

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ADDITION TO SURNAME.

C. W. R. Preston should now read C. W. Preston-Hillary.

Papers by Guy's Men.

E. P. Poulton, M.B., B.Ch., M.R.C.P., and J. H. Ryffel, M.A., B.C.: Blood Dissociation Curve in Uræmia. *Proceedings of the Physiological Society*, June 18th, 1913.

E. P. Poulton, M.B., B.Ch., M.R.C.P., and another: Possible Errors in the Estimation of Creatin and Creatinine by Folin's Method.—*Idem.*

J. H. Ryffel, M.A., B.C., and others.: Observations on Respiration and Metabolism in Cardio-Renal Patients, with special reference to Acid Intoxication.—*Idem.*

Frederick Taylor, M.D., F.R.C.P.: A Lecture on Enlargement of Spleen.—*Clinical Journal*, 23rd July, 1913.

A. H. Tubby, M.S. Lond., F.R.C.S. Eng.: Surgical Tuberculosis in Children with suggestions as to a method of treatment.—*Lancet*, 19th July, 1913.

Mr. Clement Lucas's Case of Complete Calculus Suppression of Urine (after one kidney had been removed), for which he operated, removing the obstructing stone, alive and well twenty-eight years after, æt. 65.

Since in your obituary notes of the old operating theatre (which I remember being built) you kindly refer to my first successful case of nephrectomy in Guy's Hospital, your readers may, perhaps, be interested to have a note on what I regard as my greatest surgical triumph (as it had never been done before), viz., the cure of a case of complete suppression of urine by operation on the fifth day.

I showed my first nephrectomy at the International Medical Congress which met in London in 1881, and the details of the case are to be found in the Transactions. The approach of another London Congress turned my thoughts to this case of total suppression.

Briefly, the case is as follows:—A woman, æt. 37, had suffered from hæmaturia for seventeen years. She was found to have a floating right kidney in which stones existed so large that they could be grated one on the other. This kidney proved to be a mere shell filled with masses of stone which weighed on removal twenty-one ounces. She made a rapid recovery from the nephrectomy, leaving the hospital just a month from the operation. Between three and four months later she was seized about eight o'clock one Sunday morning with vomiting and violent pain in the left loin and groin. From that time she passed no urine. I went to Sutton to see her on Tuesday evening and the husband promised if she were alive in the morning he would bring her up to Guy's. She was admitted in a collapsed condition on Wednesday and was seen by many of my colleagues, all of whom thought no good would be done by operation, and my dearest friend, the late Dr. Moxon, did his best to dissuade me as he did not wish me to injure my reputation. I consented to wait till coma commenced and had a special nurse on duty to watch. This happened about midday on Thursday, and I operated in Lydia Ward, removing a conical stone plugging the upper part of the ureter. I published the case five years later, showing the patient at the Royal Medico-Chirurgical Society in the Transactions of which it appeared in 1891. I was slow to publish the case because everybody predicted a rapid death, as she had only one kidney and that had been opened through the loin, but, of course, the wound healed completely.

On July 13th, 1913, I received a letter from Mr. E. Morgan Hearnden, of Sutton, saying that "Mrs. Fry, residing at Myrtle Road, Sutton, is still alive and very well indeed." She is now sixty-five years of age and it is twenty-eight years since the operation.

R. CLEMENT LUCAS.

The Guy's Hospital Museum of Antiquities.

AN INVITATION.

The preservation of objects connected with the history of Guy's has often been advocated in the past, and in the latter part of last year a scheme was put forward, under the auspices of the Guy's Hospital Gazette, for the creation of a special museum for that purpose. Since then the co-operation of the authorities of the Medical School has been enlisted, and a room between the Wills Library and the Gordon Museum has been renovated and repaired by them, and in it a large showcase has been installed by the Gazette.

With the assistance of Guy's men it is hoped that this room may in time become the repository of a collection of the greatest interest to all who are concerned with the splendid history of the hospital.

It was considered advisable to defer making a definite appeal for loans or gifts of this kind until it had been possible to bring together a small nucleus collection to indicate that proper provision for the safe custody of such exhibits had been made.

This collection now comprises antiquities discovered in the various excavations upon the hospital site; Roman jars, a twelfth-century bas-relief from the Abbot of Battle's Maze, and *bellarmines*, clay-pipes, etc., from the plague-pits. Besides these, there are a series of about twenty views of the hospital at different periods, some finely-engraved certificates issued by the School in the early nineteenth century, and a few portraits of former members of the Staff, and a couple of autographs of Thomas Guy. In addition, promises of material of equal interest have been received.

So much, it is hoped, will prove that the undertaking has been entered upon seriously, and a few considerations may not be out of place in regard to the manner in which the collection can be augmented. Even were the space available less restricted there are certain dangers which always threaten a small museum of this sort and which are to be avoided if it is not to become a mere aggregation of "curiosities" at which the bewildered spectator arrives to gape and remains to yawn. It seems, therefore, necessary to formulate at the outset some sort of definition of the range of exhibits which it is desirable to include, and for that purpose the following scheme is suggested:—

I. Personal relics of Thomas Guy and of the "second founder," William Hunt.

II. Objects of interest associated with the hospital and illustrating its early history and administration.

III. Portraits and mementoes of distinguished Guy's men.

IV. Antiquities from the hospital site.

Of secondary importance under this scheme, but still desirable for inclusion, would be exhibits connected with St. Thomas's during the years of the association of the United Hospitals, or of early medical and hospital interest generally. It is, of course, fully recognized that Dr. F. W. Cock's fine collection of historic surgical instruments in the Gordon Museum renders any attempt at competition in this class of antiquities both unnecessary and undesirable.

Upon such a definition it should be possible to bring together a collection that would form an exceedingly valuable series of illustrations to the story of Guy's, and it is in the power of Guy's men of all years to help to realize that ideal. If, therefore, those who are willing to assist by presenting (or lending) suitable objects will communicate with the Acting Curator, Mr. W. Wale, Wills Library, Guy's Hospital, after the re-opening of the library on August 25th, there should be little difficulty in establishing a museum which shall be worthy of Guy's.

R. M. WINGENT,
Honorary Curator.

Lines addressed to an Old Lady who expressed disappointment with treatment received in "the Consolating Room."

It was not quite what you anticipated—
Men were deceivers ever, I'll admit;
Mayhap their skill *was* slightly overrated,
Yet, though they thus prevailed on you to sit
In that strange chair too long—eheu fugaces . . !
They did not bear you malice, not one bit.
And, if you were constrained to make grimaces,
Surely you gained some sort of benefit.

You did not know such drastic operations
Were necessary now. Alas, we still
Are very clumsy with our consolations,
But, with your opportune reminder, will
Endeavour to do better. Peradventure
We *have* been too heroic with the drill;
It may be that an aptly finished denture
Consoles no better than a well-rolled pill.

If that be so, since stress of competition
Urges us ever to attain the best,
It must become our principal ambition,
Our highest hope, our utmost interest,
By dint of our amalgam and the other
Accessories that answer our behest,
To soothe the sorrows of each stricken brother
And set our sisters' lachrymals at rest.

'Twill be no easy task to put in practice
The vision that your simple soul conceived,
No easy task at all: the solemn fact is
We all should feel excessively relieved
If yet another specialized department
Might be constructed, for the mind aggrieved
And for all tribulations of the heart meant,
Where solace should be practised and achieved.

R.

Papers Received.—Clinical Excerpts. The Hospital, Nursing Times, Charing Cross Hospital Gazette, St. Thomas's Hospital Gazette, New York Journal of State Medicine, St. Mary's Hospital Gazette, London Hospital Gazette, Clinical Journal.

Chronic Cardiac Failure.

CLINICAL LECTURE BY Dr. LAURISTON SHAW, May 21st, 1913.

Gentlemen,—I am not to-day bringing before you any special case or cases for your consideration. I want to talk to you about a condition which you must often have come across, and which presents so many interesting features that in a single lecture I can only hope to deal with certain selected points. There has been a good deal said in the Guy's Student's Gazette lately about a want of enthusiasm in attending clinical lectures. Various explanations have been offered. The Gazette seems to think the fault, if fault it be, lies with the students. Some of its correspondents think it lies with the lecturers. I do not deny there may be truth in both these indictments. Students and lecturers, like the Gazette and *Punch*, never were what they used to be. I am disposed, however, to think the fault, to a certain extent, lies with the Gazette. The editor publishes our clinical lectures sometimes, and his example has been followed by other medical papers. A student naturally comes to think that if the lecturer or the Gazette reporter considers a clinical lecture is specially worth hearing it will be published, and he will be able to read it at his ease in twenty minutes or so, and can utilise the lecture hour more profitably for his lunch or for gaining experience in the wards or Out-Patient Department. Whereas, if neither the lecturer himself nor the journalist regards the lecture as worthy of report, it can hardly be wise for him, he will think, to devote to it a whole sixty minutes of the over-crowded curriculum. The printing of text-books has lessened the popularity of systematic lectures. The publishing of clinical lectures has lessened enthusiasm for attendance during their delivery.

This publication of lectures affects in another way their appeal to students. The lecturer having the fear or hope that his lecture may be published, cannot fail to have in his mind a different, and in some respects a more critical, audience than that which he is actually addressing. Now the essence of success in oral teaching, whether at the bedside or in the lecture theatre, is intimate personal contact and sympathy between the teacher and his pupil. Just as our modern examination system introduces the dead hand of the unknown external examiner between the teacher and his pupil, so does the publication of clinical lectures introduce into the lecturer's audience the ghosts of post-graduate students, experienced practitioners, and critical fellow-teachers as potential readers. The different stages of the experience of one's actual audience is bad enough as it is, without these adventitious elements. On the one hand, I see men whom I recognize as just entering the medical wards and industriously acquiring their physical signs; on the other, men who are just preparing for, or have already passed, their final examinations in medicine. It may be impossible to avoid this. But classification of the status and experience of the students is a very essential step in education, and if the Gazette won't promise to leave us alone, and not publish our lectures, perhaps some of you would ask the Editor to take into his consideration the possibility of including in his many schemes of reform the grading of clinical lectures for senior and junior students. I should ask to be allowed to teach the juniors to whom, at any rate, my remarks to-day are addressed.

When I tell you that the subject of my lecture is "Chronic Cardiac Failnre" you will understand why I want to banish from my actual or potential audience advance students of cardiology! If I thought that some were present or were likely to read what I am saying I should not dare to deal with the subject in the elementary manner I propose to.

I do not intend to say anything about heart-block or the A. V. bundle, the A. C., or the P. T. interval, extrasystoles or auricular fibrillation, nor shall I ask you to bear with me while I explain tracings from the polygraph or electrocardiograms. I don't want to make little of the marvellous advances in our knowledge of heart conditions that have been made possible by recent new methods of observation. But I would warn you against the danger of assuming that new methods of diagnosis make old methods useless, which is quite as false an assumption as that old methods of treatment that have stood the test of time must necessarily be discarded because the views of pathology on which they were based have changed. Novelties in means of diagnosis and novelties in treatment stand on much the same footing. The only difference is that exact diagnosis is in itself fairly novel and its extensions not, therefore, known to our forefathers. Whereas novelties in treatment are as old as disease itself. Some of you may have noticed a warning about novelties in treatment, which a correspondent in the Gazette, J. H. G., in a very interesting communication told us, used to be given to medical

practitioners by Sir Samuel Wilks. As the chief virtue of the new treatment, said Sir Samuel, is in its novelty, make haste and use it before it ceases to be novel. I wonder whether, if that wise old philosopher were still amongst us, he would give us the same advice with regard to new diagnostic methods. Certain it is that some of these new methods quickly go out of use, and this should, at least, suggest to us that however desirable it is for us to make use of them while we may, it is most undesirable that we should come to place too great reliance upon them to the neglect of others more firmly established.

These remarks are inspired by a general consideration of the great number of novel methods of diagnosis introduced in the last ten or fifteen years in the departments of chemistry, bacteriology, and radiography, some of which have already been declared by the specialists in those departments themselves to be of no further utility. I have been in personal touch with a generation of physicians who saw the introduction of the stethoscope. Quite properly the older physicians of those times used to smile at one of the younger generation who excused his inability to diagnose a case of pneumonia on the ground that he had left his stethoscope at home. I hope you will speedily learn to use and appreciate the value of the electro-cardiograph, but will never reach the stage of being unable to decide whether you should give digitalis in a heart case without its assistance.

But I must get to business. The subject of my lecture, as I said before, is chronic cardiac failure. I often worry you when we are going round the wards, as to the proper use of the adjectives acute and chronic in various diseases. In the condition I am speaking of to-day, acute is generally applied to cardiac failure of such short duration that the patient is either dead or out of danger in a few minutes, or at least a few hours. Chronic cardiac failure is not a less serious affection, but is a condition of some days, weeks, or months duration, and usually persists long enough to produce some of the secondary phenomena which are called, *pace* the modern heart specialists, "backward pressure" effects.

As I have said, chronic cardiac failure occurs in many conditions. In the great majority there is organic disease of the heart. Many cases of organic disease of the heart do not suffer from cardiac failure, either acute or chronic, during a long life subsequent to the development of the disease, and die of some independent condition. Many patients die from chronic cardiac failure without giving any clear indication of the exact nature of the exciting cause. Generally, such patients are sufferers from lung or kidney disease. Sometimes no obvious cause can be found even at the autopsy. In cases that recover, one can only guess that there may be some form of cardiac disease that escapes our observation, or that there is some equally elusive primary condition. It is in such cases as this that one hopes for help from the more exact methods of investigation now being introduced.

The obscurity of such cases is often overlooked when well marked bruits are heard, indicating incompetence at one of the orifices. The defect indicated by the bruit is accepted as the primary organic heart lesion, whereas it is really merely a result of the dilatation and cardiac failure, whose cause we are seeking. While this is true of bruits, indicating mitral or tricuspid regurgitation, it is not, of course, true of those indicating aortic regurgitation. For while mitral and tricuspid regurgitation may take place through perfectly normal valves, as a result of mere dilatation of the cavities of the heart, no amount of dilatation of the heart will make the aortic valves incompetent. For these to allow regurgitation, the segments must themselves be damaged; or the first part of the aorta dilatated, conditions which do not occur without organic disease of the valves, or of the arterial wall. Your knowledge of the anatomy of the heart will make it clear to you that dilatation of the left ventricle, however marked, will not lead to aortic regurgitation. Aortic regurgitation, cardiac failure is always a proper sequence for the two conditions in a detailed diagnosis. But one is in constant difficulties when sure of the existence of mitral regurgitation and cardiac failure, as to which of the two conditions should have precedence. Should one say mitral regurgitation, cardiac failure, or cardiac failure, mitral regurgitation.

Thus, with or without obvious organic heart disease, chronic cardiac failure may take place, and if its earliest symptoms, rapid pulse, breathlessness on exertion, and palpitation persist for some time, the common back-pressure symptoms which you recognize so well as the result of venous stasis will result. Of this phenomenon you can recognize two stages, firstly an overfulness of the veins with blood, and secondly an extravasation of serum into the connective tissues.

If you are watching carefully the development of these troubles in a patient, you will often recognize that the arrival of œdema will lessen

the venous engorgement, and may be a very great satisfaction to the patient so far as discomfort is concerned. The amount of space available in the vessels is limited, but the subcutaneous tissues, especially when combined with the great serous cavities, can accommodate an extraordinary amount of serum. When there is a uniform and symmetrical development of venous engorgement and anasarca as a result of cardiac failure, there is rarely any difficulty in recognizing the condition, but diagnosis becomes much more difficult when one part of the body or a single viscus bears the chief stress of the engorgement. Even when there are well-marked physical signs of cardiac disease, it is difficult to be sure that cardiac failure is responsible for, say, an enlarged and tender liver when this is the only obvious physical sign of venous engorgement. Alcohol may be suspected and called upon to explain on the one hand an early condition of cirrhosis, and on the other myocardial degeneration.

It is not an unreasonable line of argument in such a case that if heart failure had produced so large a nutmeg liver it ought also to have produced œdema of the legs, albuminuria, and various common changes in the lungs. Practical experience, however, shows that these limited changes do occur, the liver often escaping when kidneys and limbs and lungs are markedly affected, or the legs alone being anasarcous, while all the viscera may escape. The explanation is probably to be found in the engorgement of the affected part acting as an open safety valve and lessening the stress in other places, just as a serious flood in a single meadow may save adjacent property at the side of a river threatening a general overthrow of its banks. Not quite so easy of explanation is the fact that in many cases of chronic cardiac failure due to primary disease of the left heart, the lungs will not show evidences of trouble even when it is clear that the stress has passed through the pulmonary vessels and caused dilatation and failure of the right heart. With marked clinical evidence that the stress in the pulmonary vessels is occurring, in the shape of an accentuated second sound in the pulmonary area, and with subsequent pathological evidence that it has been severe and long-standing, in atheroma of the pulmonary arteries, the lung may yet itself in many cases appear to escape altogether. There may be complete absence of bronchitis, œdema, and induration of the lung. The mere postponement of these lung signs until there is already marked evidence of right-sided failure might be explained if one regarded them as expressions of stasis and exudation from the *bronchial* rather than the *pulmonary* vessels. If such an origin were established, the occasional escape, even in advanced cases, could be explained on the principle of the safety valve by which I have tried to account for the escape of the liver or kidneys when other systemic parts are affected. But I think you will find not a few cases in which œdema and bronchitis are established as a result of mitral disease before there are any indications of failure of the right heart. If this be so these changes must sometimes depend on engorgement of the *pulmonary* vessels and we should have to explain why sometimes they fail to be produced although the engorgement of these vessels has been very severe. The matter is worth your attention and might be cleared up by careful clinical observation.

Turning now to the treatment of the condition I shall, of course, give a first place to digitalis. Digitalis is in my opinion a drug which is given far too often, and when given in the right cases is constantly given in too small doses or for too short a period. Gallons of digitalis are wasted every day on patients with pulses quickened by fever or nervous causes for which it is quite useless. Other gallons are wasted on people with valvular diseases of the heart without cardiac failure who do not in the least require it. All patients with chronic cardiac failure who have both rapid and irregular pulses require digitalis, most cardiac patients who have rapid pulses require it, most who have irregular pulses require it, few cardiac patients who have slow pulses require it, few who have regular pulses require it, none who have both slow and regular pulses require it. Having by such considerations avoided the pitfall of giving it to those who don't want it, and having decided to give it to those who need it, do not fear to give it in sufficient quantity and until it produces its effect or you are satisfied that its proper effect cannot be produced.

When discussing with you in the wards the behaviour of digitalis I am generally told that its action is cumulative, which seems to be understood as meaning that after it has been given for some time something sudden and unsatisfactory will happen. I have no such experience. My ward clerks sometimes suddenly find the pulse of a patient who is taking digitalis to be very slow; the discovery is the only thing sudden about the affair. The four-hourly record shows that the slowness suddenly noted has been quite gradually produced. If a case is being properly watched ample warning

will be given before any dangerous effects are produced by digitalis. Begin with a moderate dose having some proportion to the rapidity and irregularity of the heart, increase it after twenty-four hours if no effect is produced, and do not hesitate to increase it still more until a distinct slowing has taken place or until you decide that further attempts are useless. Omit the digitalis when the pulse is reduced to 60 per minute. Do not give up the digitalis as useless until you have tried the effects of combining it with a full dose of opium. I find too great reluctance to give opium in cases in a critical condition from heart failure. It has often appeared to me to be the means of saving life. When one thinks of the effect of mental excitement on a perfectly healthy heart one can easily understand how essential are peace and contentment to a patient whose turbulent diseased heart we are trying to control. Opium can give peace.

There are other drugs, of course, with similar action to both digitalis and opium, which may be tried in certain cases or by way of change, but in a really critical case alternative drugs hardly come into consideration unless the two favourites are inapplicable on account of some idiosyncrasy of the patient.

In the advanced stages of cardiac failure we are considering absolute rest is essential. One of the greatest advancements in the treatment of heart disease made in the last thirty years is the recognition that in heart weakness as distinct from heart failure properly graded exercise is the rational treatment as opposed to the absolute rest at one time regarded as essential; but such treatment cannot be adopted in the later stages. But I would give you a word of warning with regard to the nature of the absolute rest.

Sir Samuel Wilks told me when I was his house-physician that he believed that the rigorous routine, common at that time in the hospital, of strictly confining patients, dying from heart disease, to their beds hastened their deaths and made their last days less comfortable. He thought the patients lived longer and were happier at home where they were often allowed to die in their arm chairs. The routine of hospitals is much less rigorous than it used to be. But it is difficult to secure for heart cases in the hospital or outside it the easiest posture for dying. A well constructed arm chair with suitable arrangements for supporting the arms and restraining the head from falling forward is often the best place. A good deal has been done in the way of constructing beds the shape of which can be modified to suit the comfort of the patient. We can easily get the bed made so that the patient's back can be raised and his arms supported, but I have come across no bed that can be altered so as to allow the legs to hang straight down from the knees. What we want to do is to prevent contact of the thighs with the swollen abdomen in order to provide freedom of breathing and to let the feet and legs hang down so that the anasarca can collect freely in these parts and drain away from the rest of the body. Perhaps some of you will devote your minds to constructing a bed with these desirable features.

This brings me to another point in treatment. At what stage in these cases should you, in the language of the Stock Exchange, "cut your losses" so far as the stagnant blood in the veins and the extravasated serum in the tissues is concerned. I would urge that you choose an early date. It has certainly seemed to me that the rest and the digitalis have frequently produced better effects after some blood or some serum had been removed, and that this good result was more obvious when these proceedings were not delayed too long. I have tried not to overlook the fallacy that is so constantly responsible for causing unmerited praise to be given to early active interference of all sorts. The sooner we successfully intervene in any pathological condition the greater will be the number of cases included in our statistics that would have speedily recovered without our intervention. The man who gets in his tuberculin after the first cough will "cure" many consumptives, and the man who gets out the appendix the moment he can elicit tenderness in McBurney's spot, will have a high percentage of successes in the treatment of appendicitis by "immediate" operation.

I am not urging venesection and acupuncture at the first onset of cyanosis or œdema of the ankles in all cases of cardiac failure, but I am pleading for the employment of these useful measures long before the patient is *in extremis*. I have had no experience of the method of performing venesection by means of a hollow needle inserted in the vein, as described by Dr. French in a recent issue of the Gazette. It should certainly popularize the letting of blood. Another very satisfactory way of letting blood in cardiac cases is by means of leeches applied over the liver. A very experienced general practitioner of the older school told me he was convinced that the leeches did something more than extract blood. He said that when sitting by a cardiac patient's bed and

feeling his pulse while the leeches did their work he had noticed excitement so quickly replaced by rest and peace that he believed the leech introduced some sedative at the same time that it sucked out the blood. Knowing this doctor well and his power of inspiring confidence, I was inclined to attribute the soothing influence to his presence at the bedside rather than to the leeches. However that may be, I have certainly seen remarkable improvement both in the general condition of the patient and in the swollen and tender condition of the liver follow upon the application of three or four leeches to the right hypochondrium and the removal of a quantity of blood which a priori one would not have expected to be sufficient to cause so marked a change.

I have spoken of the advantage of letting the legs hang down, so that the serum may drain from the abdomen and thorax where it causes great embarrassment to the lower extremities, where it produces no serious distress. When it gets there in any quantity it is easily let out. I still see serum let out of the legs by means of incisions by a scalpel, or by Southey's tubes. The simple method of acupuncture, by simultaneous use of three triangular needles, seems to me equally efficacious, less painful, and quite free from risk, provided the skin of the legs is prepared by antiseptic fomentation. It was recently suggested to me, that the iodine paint used by surgeons to prepare the skin for operation would be useful before this simple procedure.

Until we discover a specific cause for rheumatism which we can generally agree upon, and collectively set to work to eliminate, there is little chance of our failing to have plenty of opportunities of investigating the pathology and therapuetics of chronic cardiac failure. Cases apparently in a desperate condition respond remarkably to judicious treatment, and even when we cannot hope for the satisfaction of seeing our patient recover, we may feel our efforts amply rewarded if we can lessen the appalling discomfort that attends the last months of many of these cases.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette." Guy's Hospital, London, S.E.*

Pass List.

University of London.

JULY, 1913.

M.D. EXAMINATION.

Branch I.—Medicine.

Cox, Arthur Neville, B.S.

M.S. EXAMINATION.

Branch I.—Surgery.

Stout, T. D. M.

SECOND EXAMINATION FOR MEDICAL DEGREES.

Part II.

Cocking, A. W. | McEvedy, P. G. | McManus, D. M.

Conjoint Examination.

PRELIMINARY SCIENTIFIC L.D.S.

*Stebbings, H. V. | Wallace, F. H.

* Chemistry only.

FIRST EXAMINATION.

Chemistry, Physics, Elementary Biology, Practical Pharmacy.

d *Berry, P. H.	*b* Fasken, N. E.
ab Bradnack, G. A. A.	*c* Green, P.
ab Cox, J. R.	*c* Harrington, F. J.
c Crook, F. W.	*d* McClymont, C. G.
ab Escritt, F. K.	*d* Robertson, J. C.
ab Farrington, W. B.	*d* Saw, N. H. W.

b Thomson, J. M.

a Chemistry. *b* Physics. *c* Biology. *d* Practical Pharmacy.

SECOND EXAMINATION.

Anatomy and Physiology.

Evans, L. H. B. | Millet, H.

FINAL EXAMINATION.

Medicine, Surgery, and Midwifery.

*Jones, R. O. H.

Medicine and Surgery.

*Lucas, R. H. | Roberts, C. S. L. | *Tilbury, A.

Medicine and Midwifery.

*Gould, C. H. | Lawson, F. W.

Medicine only.

*Andrew, G. W. M.	*Scott, E. D.
*Evans, H. W.	*Taylor, E. S.
Jones, D. W.	*Whitworth, W. C.

Surgery and Midwifery.

*Barrow-Clough, J. | Bevan-Brown, F.

Surgery only.

Annesley, F. D.	*Kemp, J. W.
*Creasy, R.	Lauder, J. L.
Davies, W. L. G.	*Moberly, A. V.

Townsend, T. A.

Midwifery only.

Bailey, E. R.	Drew, A. J. R.
Beattie, F. A.	Du Vergé, P. F. J. L.

Hancock, A. J.

* Denotes completion of examination.

Nursing News.

Matron's Office.

On June 5th, Sister Lydia, Miss F. A. Sheldon, left the hospital for a holiday previous to taking up her duties as Lady Superintendent of the Trained Nurses' Institution. Sister Edith Haward who has been acting as Night Sister, was transferred to Lydia Ward, pro tem., and Miss Nora Boniface, Staff Nurse in the Theatres, was appointed Probationary Medical Night Sister.

On June 11th, Sister Marian, Miss Hancock, Hospital Housekeeper, left the hospital, and Miss Hilda Vine, Sister Charity, was appointed to succeed her in the Housekeeping Department.

On June 12th, Miss M. Beardshaw, Staff Nurse in the Electrical and Light Department, was appointed to succeed Miss Claire Hinds as Sister-in-Charge of the Electrical and Light Department.

On May 28th, Nurse Bollard was appointed Staff Nurse in the Theatres on completion of her three years' training, and Probationer Ball was appointed to succeed her as Head Nurse in Martha Ward.

On May 28th, Nurse B. Evans left the hospital on completion of her three years' training, and Probationer Macdonald was appointed to succeed her as Head Nurse in Job Ward.

On May 28th, Nurse Wittrick left the hospital on completion of her three years' training; Nurse Poole, Head Nurse in Victoria, was transferred to Queen, and Probationer Roots was appointed Head Nurse in Victoria Ward.

On May 30th, Nurse Malkin, Head Nurse in Stephen Ward, left the hospital on completion of her three years' training, and Nurse Snelling, Head Nurse in the Theatres, was appointed to succeed her.

On June 1st, Nurse C. Middleton left the hospital on completion of her three years' training, and Probationer Payne was appointed to succeed her as Head Nurse in Martha Ward.

On June 1st, Nurse Probert left the hospital on completion of her three years' training, and Probationer Eagle was appointed to succeed her as Head Nurse in Astley Cooper Ward.

On June 4th, Nurse Freshney left the hospital on completion of her three years' training, having been appointed Sister at the Civil Hospital, Bloemfontein, and Probationer Tonks succeeded her as Head Nurse in John Ward.

On June 5th, Nurse Hughes left the hospital on completion of her three years' training, and Probationer Wilson was appointed to succeed her as Head Nurse in Naaman Ward.

On June 11th, Nurse Willett was appointed Staff Nurse in the Surgery, and Probationer Fawkes, Head Nurse in Patience Ward.

On June 14th, Nurse G. Fletcher left the hospital on completion of her three years' training, and Probationer Warner was appointed to succeed her as Head Nurse in Queen Ward.

On June 14th, Nurse Finlow, Head Nurse in Cornelius Ward, was transferred to the Isolation Wards, and Probationer Garner was appointed to succeed her as Head Nurse in Cornelius Ward.

On June 18th, Nurse C. Edwards left the hospital on completion of her three years' training, and Probationer M. West was appointed to succeed her as Head Nurse in Dorcas Ward.

On June 24th, Nurse S. Simpson left the hospital on completion of her training to take up her duties on the Private Nurses Staff, and Probationer Wilks was appointed to succeed her as Head Nurse in Astley Cooper Ward.

On June 30th, Nurse Probert took up her duties as Staff Nurse in the Electrical and Light Department.

On July 2nd, Probationer Leggoe was appointed Head Nurse in Addison Ward.

On July 13th, Nurse Purves left the hospital on completion of her three years' training, and Probationer Wacher was appointed to succeed her as Head Nurse in Lydia Ward.

On July 14th, Nurse Batley left the hospital on completion of her three years' training.

The following Probationers have been successful in passing the Probationers' Examination in Surgery:—

First Class.—Probationers E. C. Baker, Barton, Broadwell, Browning, Dean, Dodds, Frank, B. Edwards, Gladstone, Goudge, M. K. Hayne, Haynes, Hayter, Holmes, Hook, Hopkins, M. L. Humphreys, Jones, Jordan, D. G. King, Knight-Law, Ledlie, A. Pilkington, Rees, Rowan, Sadleir, Thackray, Walford, and Webster.

Second Class.—Probationers Adams, Allan, Archer, Bristow, Cockshott, D. Cox, Crisford, Cruickshank, Cuthbert, Dingle, F. Edwardes, Farr, Fletcher, Franklin, Freshney, Fryer, Galagher, Galavan, Gould, Gower, Gregg, K. Hayne, Hogan, E. M. Humphries, Hyde, E. Johnstone, Kerfoot, Koester, Loughnan, Marshall, Messenger, Moss, Opie, Phillips, Rae, D. Rice, M. Rice, Richardson, Ryan, Shepherd, Sherrin, P. Smith, Shorter, A. M. Taylor, C. A. Taylor, van Weddingen, L. West, and Wolfe.

The following Probationers have been successful in passing the Examination of the Incorporated Society of Trained Masseuses:—

Probationers Brennand, Leggoe, Jenkins, Tyler-Cove, Rollo, Payne, and Wilks.

The United Guyite Club of 1868.

This Club, of which Mr. Clement Lucas is secretary, met and dined at the Trocadero, on Wednesday, July 16th, when thirteen members sat down together. The meeting was remarkable, because one member, Mr. Robert Elphinstone had not dined with the Club for forty years, and another, Mr. H. M. Langdale, had not been present for forty-three years. It was urgently impressed upon them that they should not allow so long an interval to elapse before their next appearance. Many interesting recollections were recorded, *e.g.*, how Monson Hills, the instrument man who preceded Coles, always drew the silk sutures through his mouth to make them run smoothly, and how, when torsion was used on the large arteries, the forceps invariably left the black marks of their serrations on the vessels. No wonder the surgeons looked anxiously for "laudable pus." The Presidents of the Physical Society remembered that at their teas they were supplied with buttered toast cooked by Ware, the P. M. man, before the fire in the old post-mortem room. Another member recorded how that Haines, the Dissecting Room Porter, was used to embalm Mr. Peabody, and that he scandalized the friends by cutting across the dead man's thumbs to see if his injection had run properly.

The Comparative Value of Aachen and other Methods of Treatment.

BY REGINALD HAYES.

WHAT is the Aachen treatment and how does it compare in efficiency with the modes of administering mercury more commonly in vogue, as by the mouth, by injection, or by auto-inunction?

To these questions, not infrequently asked, it is here proposed to attempt some brief reply. For the fact that their consideration will involve going over more or less familiar ground, the great practical importance of the subject must stand as excuse.

By the Aachen treatment, then, is here meant the inunction of mercury with the bare hand by skilled rubbers, conjoined with the internal and external use of sulphur water, as these methods are administered at Aachen. It is distinctive of that treatment, and of the scrupulous attention to detail and to the physical condition of the patient observed in the Aachen technique, that under no other system can mercury be used so freely, or with so great a degree of impunity.

For we must not lose sight of the fact that (notwithstanding the brilliant results obtained with antimony in the treatment of Yaws) in all phases of syphilis our sheet-anchor still is mercury. Salvarsan, wonderful, in the early stages of the disease especially, as its effects frequently are, must be used in conjunction with mercury if the best results are to be obtained.

To put in other words, the question as to the comparative value of Aachen treatment: if we assume that the province of mercury in cases of syphilis or parasyphilis be to destroy, or to assist in destroying the spirochætes as quickly as possible, and before they have time to set up a resistant strain in the body—and this with the minimum of risk to the patient—by which of the various methods of administration can that object be most cartainly attained?

For convenience let us consider each with reference respectively to clinical experience, to general suitability, and to the serum reaction of Wassermann.

From the clinical standpoint it is often very difficult, in the early stages of syphilis, to estimate with any degree of accuracy the comparative merits of the different methods, so widely do cases vary, both in the virulence of the original infection and in the patient's power of resistance. The disease, moreover, may in some instances tend to assume a latent character, or, indeed, even to get well of its own accord.

INTERNAL MEDICATION.

Taking first for more particular consideration the method of internal medication, this, although until comparatively recently the line of treatment most commonly adopted, in our own country, at any rate, may now be said to have had its day. Not so very long ago the accepted teaching was that to give small doses of grey powder, or some similar preparation, several times daily for two or three years sufficed, as a rule, to cure the disease. Doubtless it frequently seemed to do so, for usually during the course less discomfort was felt, and there was a (cessation or) diminution of symptoms. As we have seen, however, there was always the possibility that the same results might have ensued without any treatment at all. Again, when mercury is given by the mouth, the patient is brought under its influence only by slow degrees, and this fact compelled recognition of the necessity for some method of administration other than the oral in cases where severe symptoms made it especially desirable to get the disease quickly under control, as when, for instance, the chancre was on the face, or when there was occurrence of iritis, or, it might be severe pain at the seat of inoculation. In cerebral syphilis, when every hour is of consequence, oral administration has, for the same reason, proved comparatively useless, while further evidence of its weakness from the clinical point of view has been made apparent especially by its failure to prevent tertiary and parasyphilitic manifestations. The facts justifying this conclusion have, of course, taken many years to collect, but the evidence accumulated from many sources, at home and abroad, may now be regarded as decisive. In confirmation of this view may be cited, for example, the comparatively recent statement of Sir Felix Semon (1) that almost every patient he had seen with severe tertiary syphilis of the upper air passages had undergone mercurial treatment by the mouth in the early stages of the disease, not a few of them for the two years enjoined by Sir Jonathan Hutchinson.

Those who work at the special departments of the eye, skin, ear, and nervous system are all familiar with failure on the part of the internal method, as usually practised to prevent tertiary manifestation.

This is confirmed, *mutatis mutandis*, by those familiar with the special departments of the eye, skin, ear, and nervous system.

In the opinion of some observers, oral administration predisposes in an especial degree to the occurrence of intractable glossitis, with all its attendant dangers. In many instances it induces a tendency to diarrhœa, so necessitating a constant and irksome care in the dietary. It is subject, moreover, to the incidental disadvantage that the patient is often apt to regard it as dispensing with the necessity for supervision by a doctor, while it allows him only too easily to succumb to the temptation of shirking or neglecting treatment. Other objections apart, the two or three years of oral administration which is was customary to advise have, in many instances, proved grossly inadequate. In the support of this view we

have the advocacy by Henri Pelon (2) of a longer period of treatment, which he bases upon the ground that, although the apogee of tertiary symptoms may be reached in three years, they frequently continue much longer. Pelon emphasizes the further fact that general paralysis, which begins about the fourth year, becomes progressively more common up to the tenth year. Cerebral syphilis is most common between the fourth and eighth years, while tabes reaches its culminating point between the fifth and ninth.

Thus, it is from the fifth to the tenth year—in fact, just when treatment has usually been abandoned—that the patient is peculiarly liable to the three worst complications of syphilis. Of this my own experience within recent years has afforded ample confirmation; a large proportion of the sufferers from tabes and cerebro-spinal syphilis coming to me for Aachen treatment having, as it proved, taken mercury by the mouth, in the early stages, for two years or more and been pronounced cured. Yet they had, in course of time, and without there having been any probability of renewed infection, developed cerebral symptoms or tabes, with a positive serum reaction to blood or cerebro-spinal fluid.

Finally, in estimating the value of internal treatment, what is to be gathered from the evidence of the blood test? At a meeting of the Royal Society of Medicine in 1910, W. H. Bayly stated that his experience at the Lock Hospital and elsewhere made it clear that after six months' continuous treatment by pills the Wassermann test proved as strongly positive as ever. Abundant confirmation of this view is afforded by the independent testimony of J. R. McDonagh, Major French, R.A.M.C. (3), and other laboratory workers, especially of those on the Continent.

Thus we are driven to the conclusion that, when mercury is indicated in syphilis or parasyphilis, the internal method of administering it is by no means a satisfactory one. True, it panders to the time-honoured British prejudice in favour of a pill or bottle of medicine, but this is surely hardly sufficient justification. Considered from these various points of view, and in the light of the facts above adduced, it would certainly seem lacking in efficiency, and reliance upon it not in the best interests of the patient.

Injection.

Judged by clinical and laboratory results, it is beyond dispute that the various injection methods, if properly carried out, have much to recommend them in many cases. In some rare instances, indeed, injection is the only really satisfactory mode of employment, as, where time is very limited and expenditure of great consideration, or where certain skin conditions render inunction impossible. It has its uses, also, as an adjunct to that treatment.

There are, on the other hand, some disadvantages more or less inseparable from all kinds of mercury injection. Among them may be reckoned, as of not unlikely occurrence, the possibilities of considerable pain, troublesome induration, hæmatoma, abscess, and embolism. That there can be no control of the effect of the drug after introduction is a further serious drawback, while a by no means negligible objection is the not unnatural dread of the needle often entertained by the patient. Nor is it to be ignored that fatal results after injection have been and continue to be recorded. In view of these considerations it is scarcely necessary to urge the unsuitability of injection methods for general or indiscriminate application.

Auto-Inunction.

Lack of statistics precludes comparison of auto-inunction with other methods in as far as clinical results are concerned, or as tried by the serum test. While excellent in theory, and sometimes undoubtedly of great use, there is no denying that in actual practice the difficulty of carrying it out effectively amounts, in the majority of cases, almost to impossibility. As a matter of experience, there is bound sooner or later to be shirking of a task, the proper performance of which cannot but be irksome and repugnant, in view of the inevitable fatigue, not to say disgust, which it entails, and one which, to those in bad health, and to sufferers from tabes especially, is next to physically impossible. To expect a person so affected, when already enervated by a warm bath, to exert for twenty minutes at a time the force necessary for thorough inunction, and this day by day for weeks on end, is to misunderstand the condition of the patient and to underestimate the requirements of the treatment.

In auto-inunction, at all events as I have often seen it practised in this country, the axilla and groin are usually selected for treatment—parts which are quite unsuited for prolonged and thorough rubbing. It is to be noted, moreover, that the back, probably the most appropriate of all regions of the body for treatment, is also the least accessible, unless, indeed, the patient is gifted with acrobatic powers of a very exceptional order.

The verdict, then, save in the rarest of circumstances, must be against auto-inunction, if only on the score of an inconvenience amounting, as a rule, to positive impracticability. Even in the army hospitals, in spite of the comparative youth and general fitness of the patients, and the ample time at their disposal, the method has been virtually abandoned.

The completion of this brief and, perforce, cursory survey of other methods brings us to consideration of the Aachen treatment, as already here defined in general terms. For inunction, performed in the manner which the name of Aachen has come to connote—that is, by skilled rubbers (an essential point) and under proper supervision—may be claimed safety, potency, and painlessness, with exemption from most of the drawbacks which we have seen to attend other kinds of treatment.

I was led by observation of the benefit gained by many of the patients coming under my care from a stay at Aachen, to visit that place with a view to studying on the spot the methods there pursued. The courtesy of the late Dr. Feibes procured me every facility for seeing and interrogating patients suffering from all forms of the disease, among them many cases of tabes, who, as usual, formed a large proportion of the cure seekers there. Some of these had heard from the lips of eminent authorities on their malady the verdict of "incurable," and had been commended to that last medicament of the hopeless—resignation. Yet, virtually incapacitated by ataxia as they had in some cases been, they had improved under the treatment sufficiently to permit of their walking and exercising a moderate degree of activity.

Previous familiarity with English methods of inunction only tended to impress me the more favourably with the contrast in the technique adopted at Aachen. In giving some account of it, I may be permitted, in the interests of brevity, to make some extracts from a previous publication of my own on the subject (4):—

"Most striking there is the attention paid to detail. A thorough and exhaustive physical examination is made before treatment is begun. The heart, lungs, kidneys, nervous system, and teeth are each in turn carefully considered. To describe the usual procedure: The morning is commenced with a drink of from one to three glasses of the sulphur water. Next comes the bath, which is carefully adapted to the needs of the patient, the temperature being higher and the immersion more prolonged in the case of more vigorous subjects. This is succeeded by a rest and breakfast in bed, to be followed soon after by application at the hands of an expert rubber, as a rule for twenty to forty minutes, of a thirty-three and one-third per cent. mercurial ointment. The thighs, calves, arms, and back are usually treated in turn from day to day. The groins and axillæ are avoided. . . Stress is laid upon mouth hygiene. A soft toothbrush is used after meals, and a mouth-wash frequently during the day. These precautions permit mercury to be administered, if need be, even to the point of causing a condition of general lassitude and drowsiness, or intestinal cramps, without the occurrence, save very rarely, of salivation or gingivitis. The necessity for such care, as well as the extreme potency of inunction, as compared with internal administration, is illustrated by cases in which the presence of a stump, or neglect of the mouth toilet for even a day or two, has caused gingivitis during its application, in patients who had previously taken courses of mercury by mouth for months together without buccal discomfort.

"Articles of diet calculated to produce looseness of the motions, such as white wine, uncooked fruit and vegetables, are forbidden. Early hours are advised, and moderate use of or complete abstinence from tobacco, especially when the mouth or throat is affected. Plenty of fresh air and exercise, short of fatigue, are found also to contribute in no small degree to the attainment of a good result. It should not be forgotten, however, that in certain cases of nerve syphilis, rest in bed, with overfeeding and massage, prove valuable as adjuncts to the rubbing. . .

"Improvement is generally slow. Whether a particular case will do well or not, time alone can show. Some progress favourably; others, though to all appearance in the early stage and presenting an eruption, lose ground. It is impossible to tell clinically, except by a trial of therapeutic measures, whether the initial and possibly curable stage of cellular infiltration has or has not been succeeded by the graver condition of fibroid degeneration. It may be, indeed, that not true tabes, but a spinal syphilis presenting similar symptoms, has existed where good results have been obtained."

The brilliant work of Professor Mott (5) and others supplies increasing evidence that we have now, in the Wassermann test, applied to the blood and cerebro-spinal fluid and in an examination of the cerebro-spinal fluid for lymphocytosis, more scientific means than before for diagnosis, prognosis, and indications for length of treatment.

"The onset of the toxic effects of mercury in the various organs may be manifested, in the heart by palpitation, in the kidneys by albuminuria, and in the blood by decrease in hæmoglobin and disproportion of red to white corpuscles. In the nervous system it may be evidenced by tremors, and in the bowels by cramp and catarrh, while in the mouth it may be indicated by salivation, gingivitis, and ulceration.

"The subjective sensation of the patient is useful in estimating the effect on his general health. A steady loss of body-weight which cannot be otherwise explained calls for temporary cessation, or modification, of treatment.

"When, therefore, I point out the necessity for frequent and methodical examination of the various systems during this intensive treatment, the caution is more than a mere truism. Experience alone will enable one to recognise the warnings as to when the limit of physiological tolerance has been reached, and so to stop short of the further stage of toxic influence.

"Dealing with objections urged against inunction, stomatitis is usually associated with neglect of orders. Inunction has been stigmatized as dirty, but we have the testimony of patients that inconvenience in this respect is usually quite trivial. As to its being 'advertising and compromising,' I have frequently treated patients living with their wives and families without arousing any suspicion or disturbing domestic harmony. Its success, certainly, is dependent upon skill in rubbing and upon proper supervision. It cannot be ap-

plied if there is much scarring or thickening of the skin, as after variola, or in ichthyosis. Certain eruptions, or very tender skins, preclude its use, as does a marked intolerance of mercury. It involves, of course, the devotion of some time daily to treatment. Diarrhœa, dermatitis, lassitude, muscular fatigue, and pain in limbs are, indeed, consequences which may have to be reckoned with. As to inequality of action, that may not improbably be due to the idiosyncrasy of the patient or to the varying capability of the rubber."

As to the virtues of the inunction method, we have, on the other hand, the unanimous testimony of the best authorities.

"Fournier, for instance, says that he has perfect confidence in inunction *when well performed;* and, again, that he is satisfied that it is equal to, if not better than, any other line of treatment. Neumann expresses a similar opinion. A number of experts, both home and foreign, spoke strongly in favour of the inunction method, as applied to tabes especially, at the meeting of the British Medical Association, London, 1910. A similar expression of opinion being made by Drs. Risien, Russell, Buzzard, and Wilfred Harris, at a gathering of the Medical Society in November, 1911. It is of especial value if antecedent morbid states of the stomach or intestine preclude ingestion, and further, when it is required that the stomach should be left free for other remedies."

The experience of J. R. McDonagh, W. H. Bayly, and Major French (6), working independently with the Wassermann test, points clearly to the superior efficacy of inunction as compared with injection and internal administration.

It may not be out of place here to note that in general paralysis, vain as are therapeutic measures, as a rule, there unquestionably are instances in which cessation or remission of symptoms takes place under prolonged rubbings. Notes of such a case are given in the *Practitioner* of July, 1912.

The discovery of the spirochæte in the brains of general paralytics seems an additional reason for an early and thorough test of the method in this disease.

"The Aachen treatment undoubtedly owes its peculiar efficacy largely to thoroughness and close attention to detail, but hydro-therapeutics, too, have an important share in the results. The sulphur water, unless it directly assists the mercury, would be of secondary importance. But there is strong evidence of such action. The modern view is that mercury, shortly after its introduction into the body, is converted into an insoluble albuminate, and is subsequently stored in the tissues as a partially inert body. The H_2S of the Mineral water, however, unites with this and converts it into an active soluble compound which circulates freely and is easily eliminated. Thus, in conjunction with sulphur water, mercury can be given freely, the ease with which it is eliminated being shown by the amount recoverable from the urine.

"At the end of a course of mercurial treatment without sulphur water, the amount of the metal excreted in the urine has been measured for a series of days, and subsequently during a similar series of days while the patient was taking sulphur water by mouth. During the second period the amount of mercury so recovered was noticeably in excess of that recovered during the first. Consequently, large doses of the metal may be given with the certainty that, on the one hand, they will not prove therapeutically inert, and that, on the other, their toxic effect will be minimized. Temporary cessation in taking the waters during inunction is often followed by symptoms, such as lassitude, cramp, etc., which disappear upon resuming them in proper quantity.

"Perhaps the fact that introduction is effected by way of the lymphatic system, the original stronghold of the treponema, and that it enters over such a large area, may explain the rapidity with which early symptoms usually yield to its use, while in such late stages as disease of the cerebro-spinal system its application close to the seat of mischief, by the rubbing of the back, may partially account for the good results, which are possibly assisted to some extent by inhalation of the drug volatilized by the skin."

As business and other reasons in many cases preclude a visit to Aachen, and not a few who might otherwise go there are deterred by its very specific reputation, it may be well here to answer in the affirmative the question whether the treatment by inunction can be satisfactorily carried out in London. My experience during the last six years with a number of such cases leaves me with no hesitation in saying that it can. Undeviating adherence to all the details of the Aachen technique being observed, there is every justification, as a rule, in looking confidently for equally good results. The mineral water and bath salts are now to be procured here, together with facilities for their administration, while a little management will soon gain the patient's concurrence in what may be to him at the outset a somewhat unfamiliar and exacting routine.

In this estimate of the Aachen method in comparison with others, much has necessarily been left unsaid, but my endeavour has been to make it as full and as accurate as the space at my disposal allowed. I would close it with the caution that the corporeal reactions of mercury are not always calculable and are apt to have their surprises. Attentive observation must be allied with experience in each case for the attainment of the best results with the least inconvenience to the patient.

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(1). Royal Society of Medicine, Laryngological Section, January 8th, 1909.
(2). Maladies Vénéneuses, 1908.
(3). French, B.M.J., March, 1912.
(4). The intensive treatment of Syphilis and Locomotor Ataxy by Aachen Methods, 1913.
(5). Mott, F. W., Trans. Royal Society of Medicine, February, 1910.
(6). French, B.M.J., March, 1912.

Notices.

Royal Naval Medical Service.

The next Examination of Candidates for the Royal Naval Medical Service will be held at Examination Hall, 8–11, Queen Square, Bloomsbury, W.C., on the 29th September next, and following days. The number of Appointments to be offered for competition is 25.

The Regulations for Entry and the form to be filled up by Candidates will be supplied on application to the Medical Director-General, Admiralty, London, S.W. The form accompanied by the necessary documents

should be returned not later than the 18th September, 1913.

Candidates must not be under 21 nor over 28 years of age on the day of the commencement of the Competitive Examination, and must be registered under the Medical Act in force, as qualified to practise Medicine and Surgery in Great Britain and Ireland.

The Examination will consist of:—(*a*) Medicine, including Medical Pathology and Therapeutics; (*b*) Surgery, including Surgical Pathology and Clinical Surgery.

Marks will be allotted as follows:—Medicine: Paper, 400; Clinical, 400; Oral, 400; Total, 1,200. Surgery: Paper, 400; Clinical, 400; Oral, 400; Total, 1,200.

Admiralty,
June, 1913.

Appointments.

Naval and Military.

Colonel Sir A. M. Branfoot, K.C.I.E., late I.M.S., has been appointed Honorary Surgeon-General, July 16th.

Captain W. H. S. Burney, R.A.M.C., has been transferred for duty from Attock District to Khansfor Cantonment, Murree Hills District.

Captain J. H. Horton, D.S.O., I.M.S., has been placed at the disposal of the Government of Bombay for Civil Employment.

Captain C. H. Reinhold, F.R.C.S.E., I.M.S., has been appointed Civil Surgeon, Bijnor.

Lieutenant D. Reynolds, R.A.M.C., has been posted to Rawal Pindi for a course of Instruction in Indian Sanitation.

Territorial Force.

2nd Welsh Field Ambulance. Lieut.-Colonel A. W. Sheen, M.D., is seconded under the conditions of paragraph 112, Territorial Force Regulations, July 10th.

Civil.

A. H. G. Burton, M.D. Lond., D.P.H. Camb., has been appointed Resident Medical Officer of the Isolation Hospital, Deptford.

I. Samuels, L.D.S., has been appointed Dental Surgeon to the Devon and Exeter Dental Hospital.

Golf.

A Summer Competition Meeting, open to the Staff and Students, took place at Sundridge Park, on Wednesday, July 23rd, in rather boisterous weather, the events being an 18-hole Bogey competition under Handicap, an 18-hole scratch Medal, and an 18-hole Handicap Medal round. R. Curle was successful in all three events, winning the three medals and three-quarter sweepstakes, which consisted of optional 2s. 6d. sweeps, F. G. L. Scott being second, winning quarter sweepstakes.

The meeting was very poorly patronized, and it is to be hoped that considerable more keenness will be shown, especially amongst the students in the cup tie team, on the next occasion, so that these competitions may become revived regularly again after a lapse of about five years, and produce talent which is otherwise unknown to the Committee. Results:—

EIGHTEEN-HOLES SCRATCH MEDAL ROUND.

R. Curle...	82 gross.
F. G. L. Scott	83 „
L. A. Graham	86 „
G. Noott	98 „

EIGHTEEN-HOLES HANDICAP MEDAL ROUND.

R. Curle	82 – 7 = 75 nett.
F. G. L. Scott	83 – 5 = 78 „
L. A. Graham	86 – 4 = 82 „
G. Noott	98 – 14 = 84 „
A. N. Minns	109 – 18 = 91 „
E. J. Cooke	119 – 20 = 99 „

No returns from Mr. W. M. Mollison, J. T. T. Forbes, W. S. George, Graham Martin, and W. E. Tanner.

EIGHTEEN-HOLES BOGEY ROUND.

R. Curle	2 down.
F. G. L. Scott	3 „
L. A. Graham	5 „
A. N. Minns	7 „
G. Noott	7 „
W. E. Tanner	7 „
E. J. Cooke	10 „

No returns from Mr. W. M. Mollison, J. T. T. Forbes, W. S. George, and Graham Martin.

The Final of the Inter-Hospital Golf Cup, 1913, Guy's v. St. Thomas's has been postponed until October.

Royal College of Surgeons of Edinburgh.

The following have been admitted to the Fellowship:—

A. S. Roe. | R. Stout.

Birth.

PALMER.—On July 22nd, at 96, Marine Parade, Worthing, the wife of A. S. Morton Palmer, M.A., M.D., B.C., of a son.

Marriages.

DIGBY—LAW.—On 25th July, 1913, at S. Alban's, Broadheath, by the Rev. E. C. Bozman, M.A., Kenelm Hutchinson Digby, third son of the late William Digby, C.I.E., to Dorothy, youngest daughter of J. L. Law, of West Timperley, Cheshire.

WEBB—LOBO.—On July 26th, at S. Andrew's Church, Willesden Green, N.W., by the Rev. Ernest A. Morgan, M.A., W. Leslie Webb, M.B., B.S. Lond., of the Uganda Medical Service, only son of Mr. W. A. Webb, of South Norwood, to Gladys Evelyn, eldest daughter of Mr. R. W. Lobo (formerly of Fan, Turkish Arabia) of 71, St. Paul's Avenue, Willesden Green, N.W.

Death.

JOHNSON.—On July 8th, after a long illness, at Talbot Road, Bayswater, W., William Alfred Johnson, M.D., L.R.C.P., L.S.A., aged 84 years.

G. T. M.

GUY'S HOSPITAL GAZETTE.

VOL. XXVII., No. 656.] AUGUST 16, 1913. [SIXPENCE.

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Passim.

ON Friday, August 8th, the Hospital opened its gates to the members of the International Congress of Medicine. Surgery, general and special, was the order of the day, and our visitors were afforded an excellent opportunity of observing the methods and technique at present in vogue at Guy's. We hope and also believe that they found no cause for disappointment, for the proceedings passed without any serious hitch or delay. Surgeons and their firms, becomingly arrayed in the fashionable white flannels of the moment, reacted splendidly to the stimulus of the occasion, and a most interesting and representative selection of cases had been made. No small part of the organisation was voluntary and impromptu, and although it was noticeable that anticipation, both in regard to the number of visitors and the need for clear directions, had been insufficient, complaint seems uncalled for where success was generally so conspicuous.

SEVERAL hundreds of visitors attended during the day, and among them many of the world's most famous surgeons. In the list which adorns the earlier pages of the new surgeons' visitors' book, we notice among other illustrious, though frequently illegible signatures (the profession maintains its cacographic reputation): those of Kocher, Von Eiselsberg, Crile, Mayo, Murphy, Bastianelli, McEwan, Stiles, Kümmel, Körte, and Hartmann.

IT is scarcely necessary to relate that Sir Arbuthnot Lane with his colectomies was the chief attraction. The new Clinical Lecture Theatre had been fitted up for the occasion, and close upon two hundred at a time were thus enabled to watch our senior surgeon at work. To borrow a crude, journalistic phrase which we chanced to overhear, the onlookers "were clinging to the ceiling with their teeth" in their efforts to obtain a good view. Opera glasses were in great demand, and the enthusiasm was extraordinary. We were pleased to notice the presence of not a few women doctors. Lord Goschen rendered yet another of his invaluable services, by delivering an apt and opportune address of welcome to the assembled multitude after the first colectomy. His speech was received with great appreciation and much applause. The theatres in which various bone-operations were in progress, and the Gynæcological and Throat departments also attracted large audiences.

To us, and to many others, the most interesting feature of the afternoon's proceedings was the attendance, for purposes of examination and interrogation, of some twenty or more of Sir Arbuthnot Lane's "results." In spite of the

fact that the number of cases was small and the lapse of time since operation—short-circuit or colectomy—in many instances somewhat brief, the physical appearance and verbal evidence of the patients themselves, taken in conjunction with their previous histories, could not fail to convey conviction. Lane's disease is at last finding a proper recognition.

On Monday, August 11th, a function of a different character took place, a garden-party for the congress-men and their fair friends and relatives being held in the Park. Here again a word of complaint in regard to the lack of prevision and organisation must find insertion. That guiding notices and stewards, polyglot and otherwise, were provided in sufficient quantity cannot be denied, but the absence of music or any other entertainment suitable for such a gathering, and the concentration within a very limited area of the food-supplies, detracted somewhat from the gay character usually associated with social festivities of this kind, and engendered an atmosphere of mild boredom, where sociability and amusement combined with eager interest, should have reigned supreme. However, we have no doubt that our visitors, with the *politesse* that is so marked a characteristic of foreign peoples, were able to overlook these shortcomings in the midst of their keen inspection of our various departments.

One feature of interest, the Museum of Guy's Antiquities, with Mr. Wingent, the enthusiastic curator in attendance, deserves especial mention. The beautiful collection of old prints together with the other relics which are in process of arrangement there, cannot have failed to appeal to the antiquarian instincts of all those who had the good fortune to discover the museum's whereabouts.

Another interesting "exhibit," one of the historical cases of the hospital, was present in person and excellent health. An account of her case is quoted hereunder:—

A case of complete suppression occurring after the right kidney had been removed, operated on when coma had commenced on the fifth day of Anuria, in 1885, and cured by removal of a conical stone from the pelvis of the left kidney. Excellent health 28 years after, at the age of 65. By R. Clement Lucas, B.S., F.R.C.S., Consulting-Surgeon to Guy's Hospital.

F. F., æt. 37, was admitted into Guy's Hospital, June 22nd, 1885. For seventeen years she had suffered from hæmaturia at intervals, and pain in the right side. She was found to have a floating right kidney containing stones so large that they could be grated one on the other. This was removed by lumbar incision, on July 14th, and she left the hospital healed within a month. It was a shell containing 21 ounces of stone. On October 24th, 1885, in the early morning, she was seized with agonizing pain in the left loin and groin, vomiting followed and urine ceased. Vomiting and anuria continued to the fifth day, when she became comatose. The left kidney was then cut down upon and a conical stone, which acted as a ball-valve, removed from the pelvis. The wound healed completely and she has had excellent health for the last *twenty-eight years*.

The patient, her right kidney, and the stone removed from her left kidney in 1885, are shown.

There can be little doubt that, of all the discussions of the International Congress, that dealing with the question of Venereal Diseases and the duties of the State in regard to them, and especially in regard to syphilis, was the most valuable and important. The Premier's promise to institute a Commission on the subject, and the active interest displayed by press and public, lead us to hope that the social conscience has at last been awakened, and that steps will soon be taken to deal with one of the worst of existing scourges. In the solving of this, as of so many other problems, the greatest reliance is probably to be placed on educational methods. It should surely be one of our first concerns to expose to the light of day facts relating to that enemy, which has flourished so long and so insidiously in, and on account of the darkness which has been allowed to envelop it. We would even cavil at the daily papers for their absurd suppression of the names of the diseases in question. The sooner and the more the public knows about them the better; and the sooner we begin to regard syphilis and gonorrhœa as diseases *per se*, without bating our breath and assuming an attitude of shocked concern because of their associations, the sooner will it become possible for a rational attack on their origin to be inaugurated. After all, tuberculosis also is a disease which results from

ignorance and immorality—yet no one fears to discuss it. How great and criminal the neglect of Governments has been in the past we are now beginning to realize. Women have recently realized it, and have justifiably made of it a prominent feature in their claim to enfranchisement. Our own profession is also much to blame for its disgraceful apathy hitherto. Let us regard the pronouncements on Venereal Disease of the present Congress rather as an apology for our gross shortcomings, and a promise of better and wiser action in the future, than as a sudden and splendid inspiration. The shame of those who have failed even to attempt to check the ravages of syphilis and gonorrhœa is far greater than the shame of those who acquire and disseminate the diseases themselves.

The Cardiographer to his Love.

Each time I look upon thy face,
That is so exquisitely sweet,
I feel a kind of relay race
(In which my ventricles compete)
Must unavoidably take place—
No wonder that I drop a beat!

And when I hearken to thy voice,
Its music and its mystery,
For one mad moment I rejoice
That I so rich a man should be
(And so discerning in my choice),
Then throw an extra-systole.

There is no earthly force, my dear,
No charm that ever could abate
My passion's ardour. Can'st thou hear
The rhythm, can'st thou mark the rate
At which, whenever thou art near,
Mine auricles do fibrillate?

Remember, sweet, each time that I
Do claim the guerdon of a kiss,
A record of my constancy
Is made; the tambour cannot miss
The heart-block's message, cannot lie
About the bundle born of His.

Come, let us be good scientists
As well as lovers. Men may laugh,
And call us cold materialists;
Yet, if thou'lt be my better half,
We'll show that in our hearts exists
True concord—on the polygraph. R.

Simple Detachment of the Retina.

CLINICAL LECTURE BY A. W. ORMOND.

Gentlemen,—We have recently had a case of detachment of the retina in the ward, and I am using this case as a means to introduce to you to-day the present position of our knowledge and teaching on this subject. Our failure to effect any remedial benefit on certain cases should lead us to scrutinize again and again our ideas as to its pathology. Our inability to effect any permanent change for the better in so many cases of detachment of the retina has recently led us to re-examine its causes and to criticize half accepted ideas held in regard to it.

The patient, æt. 30, came to the Out-Patient Department complaining that she had suddenly lost the sight in her left eye. She had always had "weak" sight, by which she meant that she was myopic, and we found that she had $\frac{6}{12}$ vision in her right eye with a concave lens of diopters. This woman had noticed some weeks before "spots" in front of her eyes and flashes of light.

At the time of examination her vision in her left eye was reduced to the perception of moving shadows above the horizontal, and she could count fingers below her at a distance of two yards. Her vision improved slightly if the light was intensified; the pupil was slightly larger on the left side, the tension normal, and externally the two eyes looked alike.

On ophthalmoscopic examination the right eye showed the typical fundus of a short sighted eye; the left eye showed at once a diminished red reflex, the pupil looked a dull maroon colour, and in addition the lower part was darker than the upper. When this condition was more closely investigated, by direct examination, it was seen that the lower part of the red reflex altered to a green colour, and in this part of the fundus numerous small dark tortuous vessels could be focussed, although the observation was being made at a distance of ten to twelve inches from the eye itself. On going

close up to the eye, the focus of these vessels was lost, but on inserting a high plus (convex) lens in the ophthalmoscope they became distinct once more, and also it was noticed that different portions of the same vessels could be brought into focus by varying the strength of the convex lenses, thus proving that the vessels viewed in this way were on a horizontal plane, and were coming towards the observer. The smallness of the vessels, their dark colour and tortuosity, the greenish reflex in which they appear, and the varying high convex lenses necessary to focus them, completed the diagnosis.

The brilliant red reflection obtained by throwing a light into the eye, and viewing the pupillary aperture through the sight hole of the ophthalmoscope, is due to the light being reflected from the capillary layer of the choroid, hence anything interfering with this must be in front of it. In this patient, ordinary focal illumination in front showed the cornea to be clear, and also the anterior chamber and crystalline lens. We have left only the vitreous and retina. The vitreous was affected in this case, as large flocculent opacities could be seen rising and falling with each movement of the eye, but these only partially obstructed the light from the ophthalmoscope reaching the choriocapillaris.

It is the retina itself and the sub-retinal fluid which account for the greenish reflex and diminished illumination, and in our patient the detachment was mainly at the lower part of the retina. The optic disc could be seen only with a concave lens, so that the position of the vessels seen with a convex lens must be considerably anterior to the optic disc.

In health the retina is fixed to the nerve head by the fibres of the optic nerve entering the eye there and passing to form the anterior layer of the retina; at the ora serrata also, the retina is firmly attached, but between these points the retina lies against the choroid, supported mainly, if not only, by the pressure of the vitreous body. The diagnosis of the cause of this patient's sudden failure of sight in her left eye was that the retina had rapidly left its bed owing to a rapid effusion of fluid behind it; and the perimeter chart showed a large piece out of the upper part of the field of vision.

The patient was admitted to the ward, put to bed, and kept flat on her back for ten days. Various kinds of treatment were attempted which I will refer to later, but beyond a temporary improvement in her acuity of vision and a slight enlargement of the field, she did not gain very much from the efforts made on her behalf.

In some cases, certainly the majority, the detachment is "simple," that is, due to an albuminous inflammatory fluid which develops often in a short time; in others, the retina is carried forward by a solid growth arising in the choroid, or by an inflammatory mass due to syphilis, tubercle, etc. A third condition, and one much more difficult to diagnose, is due to a small solid growth of the choroid which provokes by its presence an exudation of fluid; the detachment is then due to a growth, but it has the clinical appearance of a simple detachment.

This condition should be suspected in patients who have a fluid detachment, but without any history of traumatism, who are over thirty years of age, are not myopic, and have no evidence of either a syphilitic or tuberculous taint or any heart or kidney trouble. If the intra-ocular tension is raised the presence of a growth is very probable, and transillumination of the eye will enable an accurate diagnosis to be made if the mass is in the front of the globe, owing to the light being unable to penetrate the thickened tissues, but it is not possible to obtain any information by this method if the growth is in the posterior half of the globe. Parsons first pointed out that it is not unusual to find a shallow detachment of the retina at the *lower* part of the globe in cases where there is a growth at the upper part of the globe; that is to say, there may be two detachments, one due to the growth and fluid over it, and the other due to some of the fluid caused by the presence of the growth gravitating downwards behind the retina, and causing a shallow detachment at the lower part of the globe.

It is, however, an assumption to suppose that the retina is always pushed forward by fluid developing behind it; detachment may be caused by cicatricial bands pulling the retina from its bed. Occasionally we find the retina ruptured, and a free communication present between the vitreous and sub-retinal space, both spaces being occupied by an albuminous fluid composed partly of inflammatory fluid, and partly of the vitreous humour. In this fluid the ruptured and detached retina lies.

It must be allowed that some cases of detachment are due to inflammatory fluid pushing the retina forward, and others to cicatricial bands pulling that membrane from its bed, yet neither hypothesis will explain the majority of cases,

or the failure of treatment in many instances, and the success in a few. Why is the vitreous always fluid in cases of detachment? Why, when the fluid is removed from the sub-retinal space, does it collect again almost at once? Why, with large quantities of fluid in the sub-retinal space, is there no increase of intra-ocular tension?

The most probable explanation is, that owing to pathological conditions the aqueous fluid becomes albuminous, and its passage through the retina, *i.e.*, from the choroid into the vitreous, being by a process of osmotic action, is interfered with, since the non-albuminous fluid of the vitreous chamber will tend to pass into the albuminous sub-retinal fluid until an osmotic equilibrium is reached; hence, the vitreous body would shrink, its fluid passing away from it, and the sub-retinal fluid increase at the expense of the vitreous humour. Therefore, merely to remove the sub-retinal tissue will not aid the retina to return, since more fluid will at once pass from the vitreous to replace the lost fluid, and the underlying pathological condition will not have been affected.

In youth the healthy vitreous is usually more solid and jelly-like than in old age, when it becomes more fluid, although still healthy and quite transparent. A number of cases of detachment occur in myopic eyes; detachment as a complication of myopia has long been recognised clinically. A continuously enlarging sclera would, of course, allow the formation of a space between it and the retina, unless the retina were equally stretched to cover the enlarged scleral area, but another and more probable explanation is the existence of a chronic choroiditis as the cause of the myopia, and also of fluid being secreted in the sub-retinal space.

Another ætiological factor frequently adduced in these cases is trauma, which takes place some time before the detachment appears. A blow which produces an immediate detachment must be at least sufficiently severe to rupture the retina and force the vitreous behind it, but detachment of the retina usually follows trauma sometimes as much as several months afterwards, and the causative factor is obscure. It is possible the blow has produced some damage to the choroid and retinal epithelium by which its selective power is interfered with, and as a result an inflammatory albuminous fluid is produced, and consequently the normal osmotic process entirely altered, fluid passing from the vitreous into the sub-retinal space instead of from the choroid to the vitreous.

Detachment is not unusual in conditions of nephritis, and a case was recently in the medical wards in which œdema of the face, eyelids, conjunctiva, etc., was accompanied by œdema of the retina and detachment, which entirely disappeared after the patient recovered from the acute attack. The term recovery is used in a variable sense by some writers. Do we mean by recovery, reattachment of the retina only, or reattachment with recovery of function also? In some cases recovery has been complete, and no evidence, either ophthalmoscopic or perimetric, of the detachment has remained. On the other hand, reattachment of the retina has taken place, but the presence of pigmentary degeneration and diminution of the field of vision, with very depressed visual acuity, have proved the existence of considerable damage to the retinal structures.

Treatment of detachment of the retina.—The treatment of simple detachment of the retina consists in keeping the patient lying flat on his back in bed, with his eyes under the influence of atropine, and bandaged. The elimination of any toxic properties present in the body as well as a lessening of the fluids in the eye are obtained by free diaphoresis. This treatment should be persevered with for three or four weeks, but is, unfortunately, only temporarily successful; the improvement usually obtained being an enlargement of the field of vision and an increase in the visual acuity. This, however, is often not maintained after the patient has been walking about for a few weeks.

If any choroidal inflammation is present or any specific cause for such choroiditis is suspected, treatment directed towards this should be tried as no doubt a chronic inflammation of the choroid may be responsible for the detachment although it may be difficult to prove the existence of the choroidal trouble. If no improvement has taken place as the result of this treatment various operative methods have been suggested for the purpose of draining the fluid away from the sub-retinal space: trephining the sclera, incising the sclera, inserting a thread through the sclera and leaving it in situ, so as to allow the sub-retinal fluid to escape and the retina to fall back on to the choroid. It is probable as I have already pointed out that the assumption that the retina is pushed away by the sub-retinal fluid present behind it, is not the ultimate factor in the pathological condition. The retina as has been said is often found to be torn and the vitreous and sub-retinal spaces already communicate freely. If this is not so, the osmotic

process is allowing an interchange between the albuminous and saline fluids present on each side of the retina, and in course of time the fluids become of a similar consistence. The injection of artificial vitreous media into the eye, or the vitreous of animals, has been tried on the Continent, but mainly experimentally on animals. The results of this procedure have not, however, been so successful as to encourage its application to human beings with much hope of success.

Although the treatment of detachment of the retina is by no means satisfactory, it is not so hopeless as it is sometimes considered. An improvement usually follows rest in bed, etc., and this may be permanent. Numerous instances of spontaneous recovery both with retention of function and without, have been recorded. I saw a lad only the other day whom I had not seen for five years; when first he came under my notice he had a large detachment of the retina, but on his second visit this had entirely disappeared; as, however, the function of the retina had been lost the patient was quite ignorant of the change in his eye. In this case choroiditis due to inherited syphilis was probably the ætiological factor. Another case was in a girl of 18, who was treated in the Out-Patient Department for a high degree of myopia and some myopic choroiditis; glasses were ordered and her vision noted, that of the left eye was very defective owing to the lens being partly cataractous. A fortnight later she appeared again saying that sight had suddenly gone in her right eye, and she was led into the Out-Patient Department. On examination I found a large semi-opaque detachment on the outer side of the right eye, which was certainly not present 14 days previously. She was admitted into the ward and I punctured the sclera with a Græfe's knife letting out a quantity of sub-retinal fluid. Three days later the retina had returned to its place and when I saw her last, two years after the operation the retina still remained attached and her vision was $\frac{6}{60}$. The scar of the wound could be distinctly seen as a white line in the choroid.

Mr. Higgens has kindly sent me notes of two cases he has had in which a spontaneous cure has resulted after the detachment had been present some time. The first case was in a myope, æt 27, in which detachment occurred in both eyes, and recovered in one eye only, quite suddenly and spontaneously. The second case was in a woman, aged 67, who had a detachment in the upper part of the retina, which subsequently shifted down. Four years later it had disappeared, and only a few pigment spots remained to mark its position. Unfortunately, we do not learn much from these spontaneous cures, as it is quite impossible to say why they recovered, as in many cases the treatment tried had been discontinued long before recovery occurred. That such cases do recover is, however, hopeful that further observation may indicate some practical method of treatment.

A Notable Indian Ophthalmic Clinic.

I HAVE recently had the privilege of working for six weeks in what is probably one of the finest Ophthalmic Hospitals existent at the present day, and one in which the clinical work is almost unlimited, and the methods of dealing with it are as scientific and up-to-date as anywhere in the world. I mean the Government Ophthalmic Hospital, Madras, where, under the the superintendence of Lt.-Col. R. H. Elliot, I.M.S., about 1,500 operations are done annually, and 12,000 or 13,000 new patients are seen every year. I have thought that a short account of the activities of this great eye centre may be of interest to Guy's men, and especially to those who may be contemplating specializing in this branch of surgery, for here is a great field for practice, and Col. Elliot welcomes workers and gives them every opportunity of becoming proficient in all the departments of this branch of surgery (operations, ophthalmoscopy, retinoscopy), and offers them especial facilities for pathological research.

The hospital is built in blocks, which are connected with each other by covered corridors, and, that blind or bandaged patients may not trip on steps leading from one block to another, the floors of these corridors are graded, and there are no steps. The floors of all wards and operating theatres are of marble, and the walls are of glazed tiles, to 8 feet, to facilitate cleaning. There are 144 beds, and a further 34 will be added in a very few months, a septic block having been built which is rapidly nearing completion. Electric light and electric fans are installed throughout the hospital, and the different blocks are connected with each other by telephone; there is also a piped water supply, which may not strike you, at home, as being unusual, but is a luxury to nine-tenths of us working in India.

The aseptic operating theatre is in a separate block, together with a waiting hall, the retinoscopy room, and the dark-room. The theatre is a large, well-lighted room, with a north light and two glass operating tables; it contains a minimum of furniture, all of which is sterilisable. Instruments are sterilised in an adjoining room, connected with the operating room

by a battery window. An electric steriliser is used, and a high-pressure autoclave for dressings. Septic operations are done in the old theatre, which is in what is now the Out-Patient Block.

An unusual feature of this hospital is an additional examining room which is situated in the main block, and between the large wards in which the glaucoma and cataract cases are housed. This is another well-lighted room with two glass tables and an adjoining dark room, and its especial purpose is for the examination of all intra-ocular operation cases both before and after operations. All dressings and after-treatment of intra-ocular operation cases are done here, and accurate notes made of the progress of cases.

There is a small Pathological Laboratory in a separate building, fitted with all the modern appliances for cutting and staining sections, and micro-photography, an epidiascope for teaching purposes, and a most valuable collection of mounted pathological eyes. One is especially invited to work in this department, and every facility is offered to men wishing to do so, the work being, of course, credited to them, while they make due acknowledgment of the source of supply.

The dark-room is a veritable treasure-house. None but electric ophthalmoscopes are used, and in separate cubicles will be found a corneal microscope, diaphanoscope, Edridge Green colour perception lantern, astigmometer, Hugo Wolf's retinoscope, and a Myrowit's refractometer, the last two being particularly valuable labour-saving appliances for the tedious work of testing refractions, especially in this country. All these instruments are adapted for electrical illumination.

Now for the work done in the hospital. By dint of many years' experience Col. Elliot has evolved a routine which works with almost monotonous smoothness. Every individual on the staff has a definite job, supervised by the Superintendent's invaluable Chief Assistant, Lt. Craggs, I.S.M.D.; from Mr. Taylor, I.S.M.D., the excellent Pathological Assistant, through the Indian Assistant Surgeons, in charge of various departments, to the unintelligent Tamil Coolee dressed as a peon, whose whole duty is to do certain things in a certain way at a certain time, there is no overlapping of jobs, and anyone doing other than his proper work is punished for his presumption. The result is admirable, and, indeed, this mass of patients could not be efficiently dealt with unless there were some such system.

Out-Patients are seen every morning by one Assistant, and serious or interesting cases kept for the Superintendent, who visits this department daily after his "clean" work.

Trachoma, with its sequelæ, pannus, entropion, corneal leucoma, is intensely common. Lachrymal sac disease also furnishes a large number of cases, and corneal ulceration, which has been allowed to reach an appallingly advanced stage, is too frequently seen. English visitors will be struck by the lateness of the stage at which most Indian patients come for relief. Cataract patients generally wait until vision in the second eye is reduced to hand movements, and glaucoma cases rarely seek relief until the vision has been almost completely destroyed, having ignored the early symptoms of pain and flashes of light, of which one can frequently elicit a history.

Corneal ulcers are generally already complicated by iritis and hypopion, and entropion cases frequently seek relief only when the cornea has become utterly opaque and insensitive. Many of these patients have had their eye irretrievably damaged by the malpraxis of native quacks, whose name is legion, and it is no uncommon sight to see small children brought to the hospital who have been totally blinded by the activities of these gentry who have treated them for granular lids or ophthalmia, while many of the cataract cases have already lost one eye at the hands of the coucher.

Trachoma cases are treated with silver nitrate in strengths of not more than 10 grains to the ounce, and the lids are "rolled" under cocaine anæsthesia when the granules are exuberant. Nearly all patients come for daily treatment to the hospital, as they cannot be trusted to carry out efficient treatment in their own homes. Minor and emergency operations are done in the Out-Patient Department daily, such as chalazion, hypopion ulcer, pterygium, and peritomy for pannus under cocaine, evisceration of the eye under ethyl chloride, and enucleations under chloroform.

Retinoscopies are done three days a week in another department of the hospital, and a never-failing supply of interesting fundus cases are always to be found in the dark-room, congenital defects, syphilitic choroido-retinitis, retinitis pigmentosa, and other rarer conditions, which may always be compared with classical coloured plates representing typical examples of them, and Col. Elliot is ever ready to demonstrate these with a lucidity and enthusiasm which cannot but be stimulating to the student.

On Mondays the important work is the examination of cataract cases for operation on the following day, and Col. Elliot is most careful in his selection, rejecting any with the slightest suspicion of lid or lachrymal trouble for further treatment, and to this and to his aseptic ritual before operation may be ascribed the practical disappearance of sepsis after cataract operations in this clinic, which is no light achievement in India. There has not been a single case of suppuration following the last 2,000 operations for cataract in the Government Ophthalmic Hospital, Madras!

The selected cases are carefully tested for perception and projection of light, the depth of the anterior chamber and the tension noted. The skin round the eye is washed with synol soap, and the lashes cut and a trial bandage put on. If the lint is stained with more than slight mucus next morning the case is rejected for further treatment for a week.

Tuesday is an operation day devoted to cataracts, of which there may be 15 to 50, and very rarely less than 10 cases. The eye is bathed with 1-3000 perchloride of mercury prior to operation, and several instillations of 4 per cent. cocaine at three-minute intervals give perfect anæsthesia. On the table, the eye is washed out with 1·4 per cent. saline solution (isotonic with the tears), the conjunctival surface of the lids and fornices being gently rubbed with cotton wool pledgets on sticks the while to dislodge the bacteria-laden mucus which has been evoked by the brisk perchloride washing. The secretion from the Meibomian follicles is also expressed, and after a final washing with saline, the orbit is aseptic and ready for operation. All instruments are used dry, and cutting instruments are also sterilised by boiling, it being found that one minute's exposure to boiling water has no ill effect on their edge.

Col. Elliot favours the old operation by capsulotomy. Atropine is instilled before operation, and the capsule is lacerated by means of a Bowman's needle introduced into the anterior chamber before making the section. Col. Elliot claims for this modification that one can see exactly what one is doing, that one can gauge the character of the cataractous lens and modify one's incision accordingly, and that there is less risk of dislocating the lens in laceration when it still has the support of the aqueous humour in front. He aims at cutting out a central piece of capsule with the needle (and succeeds in doing so in nearly all but Morgagnian cases), and thus lessening the density of the after cataract. A corneo-scleral section is made and an iridectomy is always performed. After delivery, McKeown's irrigator is invariably used with a solution of ·7 per cent. sterile saline, and an astonishing amount of capsule and cortex removed by its stream, some being invariably unearthed from under the scleral lip of the section.

The patients are carried back to bed, and absolute rest is only enforced for 24 hours after operation. The first dressing takes place on the third day after operation.

Only 5 to 10 per cent. of the patients require needling for after cataract, but it must be remembered that by far the majority of them are absolutely illiterate, and are content with a much lower degree of vision than a European patient would demand.

Thursday is devoted to other intra-ocular operations, and on Wednesday these patients are carefully "vetted," and notes taken of their cases. The tension in glaucoma cases is taken with a Schiotz tonometer, and where the patients have sufficient sight or intelligence, perimetric readings are recorded. In all cases of glaucoma uncomplicated with cataract, and in those in which a cataract is present, but "the lens is not semi-fluid, and no great forward movement of the lens and iris have occurred," Col. Elliot does his operation of trephining the anterior chamber. Space forbids my describing this fascinating and scientific advance on the older methods, but those who are interested may hear all about it at the International Congress in London in August, when Col. Elliot is to be one of the openers of the discussion on glaucoma. The operation is also done prophylactically on the second eye, when glaucoma has only yet affected one, and is eminently suited to cases of staphyloma of the cornea, to reduce the deformity. All trephining cases are examined on the following day, when the tension is usually found to be subnormal, and filtration established through the trephine hole between the anterior chamber and the subconjunctival tissue. I had the good fortune to see some of Col. Elliot's earliest trephining cases while I was in Madras, and two of these who had been operated on three and a half years previously showed perfect filtration and undiminished vision.

Friday is associated with the pleasurable excitement of dressing Tuesday's cataracts and Thursday's glaucoma cases, and noting their progress. Atropine drops are instilled in both cases as a routine, unless specially contra-indicated, and dionine drops used in the former, if there is evidence of much capsule or cortex left to be absorbed. Absorption is further hastened after a week or ten days by subconjunctival injections of normal saline (1 c.c.) twice or thrice a week.

Saturday is set apart for extra-ocular operations, and there is always a good crop of cases for extirpation of the lachrymal sac. Lachrymal sac disease is very common in Madras, and the patients will not submit to the tedious and uncomfortable operation of frequent probing, and, indeed, why should they? The radical operation offers a permanent cure, epiphora is never complained of, and the resultant scar is practically invisible.

It will be seen from the above very imperfect account that life is pretty busy at the Government Ophthalmic Hospital, Madras, and that there is plenty of work to be done. Moreover, Col. Elliot welcomes keen workers, and gives them early opportunities of *doing* things, and not watching other people do them. During six weeks I was allowed to do 54 cataracts, 15 trephinings, 27 extirpations of the lachrymal sac, 16 iridectomies, and a host of other minor operations, besides an occasional rare one, such as an opticociliary neurectomy.

There is an enormous amount of clinical and pathological material, for research work, much more than the present staff has leisure to deal with, and anyone wishing to follow up a particular line is encouraged to do so, and cannot but be infected by Col. Elliot's enthusiasm for the scientific side of ophthalmic work.

As to Madras itself, the best time to visit it is during the winter months, November to February, from the point of view of climate, but there is more work doing in the summer; still, there is no season of the year when there is not plenty of practice, and I should not advise visitors from England to come out during the hot weather. There are two excellent hotels and a club which is deservedly reputed to be the finest in India.

Guy's men who may be contemplating this visit to the Mecca of ophthalmic surgery would do well to read "Notes from an Indian Eye Clinic," in the *Ophthalmoscope* of April, 1912, by Mr. Temple Smith, who visited Madras eighteen months ago, and I shall be pleased to give them any further information if they will write to me. I am quite sure such a visit would be of the utmost value and would never be regretted.

Bijnor, U.P., India,
June 8th, 1913.

C. H. REINHOLD,
Captain, I.M.S.

A Rare Case on the District.

On June 25th, 1913, L.M., of 20, Whickham Place, Tabard Street, sent to the hospital for assistance at her confinement. She had been having strong pains at intervals of ten minutes for the six preceding hours. On examination of the abdomen it appeared to be slightly larger than is usually associated with a uterus containing one fœtus, and its shape suggested no malposition. On palpation the disposition of the uterine contents was difficult to ascertain, but two fœtal heads could be felt, the one high up on the right of the fundus, the other in the left hypogastrium; a fœtal heart could be heard beating at the rate of 140, one inch to the right of and below the umbilicus.

On vaginal examination, the os was three-quarters dilated, and an elongated bag of water containing a leg and a soft structure that might have been a cord, could be felt, but this latter was too high up to admit of its substance being properly felt. The pain diminished in strength and frequency after an hour's wait, and the R.O. was then called for. He agreed on the difficulty of defining the fœtal positions and confirmed the diagnosis of a leg presentation. The membranes were ruptured and the leg pulled down; after waiting for an hour and a half a living child was delivered by gentle traction on the leg. Upon further examination, another bag of water was felt; this was ruptured and an arm came down. Version was here indicated, but having given due consideration to the exhausted condition of the mother, her reluctance to take an anæsthetic, and the very septic condition of the room, it was decided that the woman should be immediately taken into the ward. Here she was anæsthetised without delay, and examination showed that, apart from the presenting arm, two legs had come down in the interval; the arm was pushed up, the legs pulled upon and a still-born child delivered. It was now apparent that a third fœtus remained in the uterus; this was quickly delivered, feet first, and artificial respiration successfully performed. The after-birth, consisting of two placentas and three distinct amniotic sacs, was sent to the museum for preservation.

The first child weighed 5lbs. 4ozs., the other two weighed 5lbs. each, all were boys. The puerperium was normal throughout.

The case is interesting on account of the rarity of triplets, there being only about one other case recorded in the district for at least 14 years; moreover, the labour gave the woman her tenth son, she had no daughters. It is instructive because (i.) the relatively small abdomen was not at all suggestive of triovular pregnancy; (ii.) careful abdominal examination revealed only two heads and one fœtal heart, the unsuspected presence of the third fœtus accounted for the difficulty in accurately defining the fœtal positions; (iii.) it goes to prove that a transverse position, as indicated by an arm presentation, is essentially one degree of "fœtal obliquity." In this case, although an arm presented, the fœtus lay nearly vertical in the uterus, the head being pushed slightly to the left side of the pelvic brim.

T. W. SHELDON.

I am greatly indebted to Mr. Chapple and his R.O. for their permission to publish and for their revision of these notes.

A Case from Practice.

J. F., æt. 53, consulted me on September 28th, 1911, complaining of pain in the epigastrium.

Family History unimportant.

Personal History.—Patient stated that he had good health until a few years ago, when he began to have "attacks of indigestion." The chief symptoms were pain in the stomach, constipation, and occasional vomiting. During the last two or three weeks the pain and vomiting had been more persistent.

On examination I found some tenderness in the epigastrium, the area affected inclining somewhat to the left. There was a good deal of resistance on palpation, but it was difficult to say whether a tumour were present or not. The liver dulness was normal, and the spleen could not be felt. Examination of other organs was negative. Urine normal. Weight, 9 st. 4½ lbs. Patient

was a tall spare man with a sallow complexion. He thought he had lost some weight, but was not very decided about it.

Treatment.—Purgatives and stomachic with regulation of diet.

Patient rapidly improved, and at the end of a fortnight said he had "not felt so well for years." The tenderness and sense of resistance in the epigastrium had disappeared.

On February 6th, 1912, I again saw him. His stomach symptoms had returned, but were not so severe. Examination of the abdomen showed tenderness over the same region as before. Patient also complained of a nasal discharge. Weight 9st. 6lbs.

Treatment.—As before, but nasal discharge was also treated.

Patient remained well until January, 1913, when he had slight pains in the stomach. On March 3rd he again consulted me. The pain was much worse and the vomiting had been very troublesome. He had just returned from his holidays in the hills (a cool climate), and attributed his trouble to coming back just at the time of a spell of hot weather. Weight: 9st. 7lbs.

On examination I found a large mass extending from the middle line to the left and filling the left hypochondriac region. It was not evident on inspection, but on palpation felt hard with a fairly definite outline. On percussion there was absolute dullness or rather flatness.

I sent the patient to a consultant (distance prevented my being present) and the report was "cancer of the cardiac end of the stomach or of the transverse colon."

On Monday, March 17th, an exploratory operation showed chronic interstitial pancreatitis.

For about a month after operation patient improved and seemed very well. He then complained of pain and was troubled with vomiting. The abdomen was distended, but there was no dulness and no tumour could be felt. The mouth and throat became extremely dry, the salivary secretions having apparently ceased.

Various pancreatic preparations were tried, including the fresh gland, but the patient gradually sank and died on May 5th.

J. F. HUTCHINSON.

Change of Address.

G. Dunderdale, M.D., B.S., M.R.C.S., L.R.C.P., from Guy's Hospital to c/o Chief Secretary to Government, Nairobi, British East Africa. (To be forwarded.)

Fleet-Surgeon W. Bett to H.M.S. *Dreadnought*, 4th Battle Squadron.

Fleet-Surgeon C. Marsh Beadnell, R.N., to H.M.S. *Achilles* (Cruising). G.P.O. London.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Some Remarks on Orthodontic Measurements.

CLINICAL DENTAL LECTURE BY J. B. PARFITT.

In the course of his practice a dental surgeon is often asked whether a certain child's teeth need regulating or not. In order to answer this question it is necessary to have a clear idea of the correct position of each individual tooth in the particular case in hand, or what comes to the same thing, in what direction, and how far each tooth is removed from the position it ought to occupy. Hence, we are naturally led to the idea of a certain ideal shape, which might be called a correct or normal arch. This has proved a very attractive study, and many shapes have been proposed in the past years, each one believed by its author to be the ideal form of the perfectly developed set of teeth. It may not be without interest to notice one or two of these.

As long ago as 1800, Muhlreiter wrote that the upper teeth are implanted in a curve which forms half of an ellipse. The shorter axis, which unites the posterior cusps of the two upper wisdom teeth, is from 5 to 5·5 cm. long, and the half of the longer axis is from 5·7 to 6·2 cm. long. Herber, to whose article I am indebted for the information, points out that an ellipse, the focus of which lies one-tenth of its length from the end of the major axis, gives a shape very like that of a well formed arch, and speaking personally, I think it is a good deal prettier shape than some others arrived at in a much less simple fashion. The idea of making a geometrical construction also appealed to the famous Dr. Bonwill. He noticed the fact that the lower jaw is about as wide from condyle to condyle as it is from either condyle to the division between the two front teeth. In accordance with these measurements he constructed an equilateral triangle, and then by the help of various lines and circles deduced the positions of the teeth in the arch. It is, however, only fair to say that the patient himself was still further brought into the calculation by measuring his front teeth and plotting out their actual widths on the diagram. Others, following Dr. Bonwill, apparently had more ambitious aims, and tried to deduce the sizes of the teeth as well as their positions. I think the most famous of the attempts to find an "ideal arch" is that of Dr. Hawley.

Dr. Hawley, working somewhat on the lines of Dr. Bonwill, tries to deduce the size and shape of the arch from the measured widths of the upper six front teeth. This is a most excellent idea if it can be shown that there is a definite correlation between the sizes of the front teeth and those of the back ones, and common observation tells us that some such correlation exists. We want to know the proper positions of the teeth before they erupt, not after they are all in place, when it may be too late to do much good, and Dr. Hawley made a very real attempt to overcome this difficulty.

Dr. Hawley's plan is to measure the widths of the three front teeth of one side, and describe a circle whose diameter is equal to these three widths added together. One third of this circle, that is an arc of 120°, will then, according to Dr. Hawley, exactly represent that part of the patient's arch which should be occupied by the six front teeth. I think few would be inclined to quarrel with this; 120° of an arc of a circle is quite a good shape for the line of front teeth, and the canines are in good alignment for the bicuspids and molars that follow them.

I must confess that the rest seems to me much less satisfactory; the positions of the cheek teeth are deduced by a construction that I cannot help calling nonsensical. The final result of the construction is that the premolars and molars are placed in straight lines back from the canines on either side, diverging outwards in such a way that if they were produced in a forward direction they would meet somewhere in front of the incisors and make an angle of 42° with each other.

To me this arch seems unnatural, it looks too wide at the back, but whether this is the case or not, neither this shape nor any other will be of any use if considered apart from the other jaw. Dr. Angle and the rest of the modern orthodontists, recognizing this clearly, insist on the fact that the denture as a whole forms a single piece of mechanism, and that, like cogs in a gearing, each tooth can only fulfil its function properly if it is in correct relation with its neighbours of the same jaw and its antagonists of the other.

This is the reason for their insistence on the importance of "occlusion," in other words, the principle that function is the true test whereby a set of teeth must be judged, and not the mere shape of one of the arches as it appears in a diagram or on the model.

It should be noticed that what is called "correct occlusion" is generally a position of stable equilibrium, the arches being kept from spreading by the inward pressure of the lips and cheeks, and from crumpling up by the outward pressure of the tongue and the support the teeth mutually give to one another; moreover, each tooth is locked in its place by the opposing surfaces into which it fits. Another fact that is well worthy of remark is that the "inclined planes" of the masticating surfaces of one jaw which limit the movements of the other one, form as it were a solid record, a sort of locus, of those movements, so that if one tooth is missing from the arch the opposing teeth would in the ordinary course of mastication sweep out in space, or in some soft substance placed in the gap, a very exact reproduction of the masticating surface of the missing member.

Of course "occlusion" of itself gives no clue to the position of the denture in relation to the cranium, so it has generally been assumed that the upper sixth year molars are correctly placed, and the positions of the other teeth considered in relation to them.

In many cases this assumption leads to perfectly satisfactory results, but it is well recognized that the upper sixth year molars are by no means limited to one invariable position in relation to the rest of the cranium; for instance, they are liable to come forward owing to loss or decay of the temporary molars; I have seen several cases in which the first upper molar has been in contact with the canine. As no other tooth can even pretend to afford any sort of landmark, movement of the first molar puts difficulty in the way of diagnosis of the nature of the irregularity. The simplest way to avoid this difficulty is to consider the case in relation to the prominence or otherwise of the upper front teeth, as compared with the rest of the features in the profile.

Appearance, after all, requires consideration as much as function; moreover, while there are several arrangements that would give good functional articulation, very little deviation from one particular position of the front teeth would spoil the appearance altogether. The first thing to do then in considering a case for regulation, is to find out the character of the profile, and especially the position of the upper lip.

Attempts are now being made to get definite measurements of the positions of the lips and chin in relation to the rest of the profile. The way this is done is to place over the photograph of the patient a transparent screen divided into small squares by lines one millimetre apart from one another. If a base line

be chosen measurements can be made by the simple process of counting the lines between the base and the point required. If two base lines are taken at right angles to one another, the method will be nothing more than the application of the ordinary co-ordinate notation to our measurements.

There are, however, two difficulties—the finding of, first, a base line, and then fixed points on the features to be measured. To an anthropologist all features are variable, and, of course, there is no such thing as a "vertical" or "horizontal" line, because there is nothing to show what position of the head can be called "vertical."

Some idea of a way of overcoming these difficulties may be got by studying a very interesting scheme of portrait measurement published in *Nature* a year or two ago by Francis Galton. The scheme is based on the fact that the profile consists of a series of curves, some convex to the left and some to the right, and that a common tangent can be drawn to a pair of them. One of these lines gives a base line, and the various intersections of the lines give the points for measurement, the accuracy of which is only limited by the degree of sharpness of the photograph.

It has been well pointed out that if you draw a line across a photograph just below the nose you divide the face into two parts in such a way that the features an orthodontist can alter all lie below the line, while those he cannot alter are practically all above it. Thus, while to the anthropologist or criminologist all features are variable, to us certain of them must be considered fixed, and we can use the ones we cannot alter as a standard for measurement of those we can.

The actual plan that has been used to some extent is to take, as a base, the line which touches the re-entering curve at the root of the nose, and also passes through the point of junction of the nose and the upper lip; this latter can be fixed, with a very fair degree of accuracy, by noticing the point where a line making an angle of 45° with the vertical base line, just touches the rounded off angle between the nose and the upper lip. This line may quite fairly be called the axis of that part of the face which is to us unalterable; likewise, the distance between the lower border of the upper lip and the top of the eyebrow may be taken as the length of this fixed part. It is quite easy then to measure, by means of the lines on the squared screen, the amount of projection severally of the nose, lips, and chin. For the purpose of comparing different photographs, the measurements of the lips and chin can be brought to a kind of common scale by dividing each one by the length of the fixed part of the face.

Having made up our minds, by help of measurement or otherwise, the amount of prominence of the upper lip, the lower lip, and the chin, we are in a position to decide—

(1) Whether the upper front teeth should be left alone, or retracted, or brought forward.

(2) and (3) The same, with the lower lip and chin.

There remains, of course, the difficulty of knowing what changes would occur in the face in the natural course of growth, and just how much to allow for growth in our estimations. We are hoping that in course of time we shall get from accumulated measurements, some useful information on these points.

When once the ideal position of the front teeth is settled, the consideration of the back ones is a comparatively simple matter.

The Resurrectionists.

I.

"*With instruments upon them, fit to open*
These dead men's tombs."
Romeo and Juliet, V., iii.

THE history of medicine contains no passages more astounding than those concerned with the provision of anatomical subjects in England previous to the fourth decade of the nineteenth century.

The story of the manner in which human bodies were obtained in these earlier years has been related, from varying points of view, by Bransby Cooper, in the "Life of Sir Astley Cooper"; by J. F. South, of St. Thomas's, in the autobiographical section of his "Memorials" (from which is derived the account in Wilks and Bettany's "History of Guy's"); and by Dr. William Rendle, "a Student of Guy's in 1830," in the GUY'S HOSPITAL GAZETTES of 1889; and the whole subject has been reviewed by Mr. James Blake Bailey in a small volume entitled "The Diary of a Resurrectionist." All these books are now "out of print," and the story of the *body-snatchers*, therefore, may be worth re-telling to-day.

The study of anatomy had no real existence in this country during the Middle Ages, when the whole profession of medicine was under clerical control. It was the Renaissance that first brought new conceptions of science to England from the Continent. Later

still, the Company of Barber-Surgeons was re-organised under the patronage of Henry VIII., in whose reign was passed the law which allowed the Company to have, yearly, the bodies of four male-factors for "anatomyes," a number that was increased in after years. As, however, it was discovered "that persons in London, aliens, foreigners, had obtained many dead bodies, without lawful warrant, by bribing officers and dissecting in private; it was therefore ordered that no dead body should be carried from the place of execution (that being the usual or only supply) to any private house or other place to be dissected, but only to a public place fitted for such a purpose, namely, the Barbers' Hall." As a sequel to this enactment John Dean was fined, on May 21st. 1573, for having an anatomy in his house contrary to order.

Broadly speaking, however, it is true that the study of anatomy dates only from the time of Harvey, whose discoveries first gave the necessary impetus to the science in the following century; and the reign of Queen Anne arrived before the new race of surgeons began to free themselves from the restrictions imposed upon them by the Barber-Surgeons' Company. So long as this Corporation was able to enforce its exclusive privilege in the teaching of anatomy at its hall in Monkwell Street, the supply allowed by law from the execution of criminals was quite sufficient for the purpose; but complaints were heard, as early as 1706, that the Company's Beadle, attending the removal from Tyburn, had been molested by armed soldiers who took away the bodies in coaches.

The more ambitious surgeons were breaking away from the Corporation to deliver lectures privately, and the demand for anatomical subjects increased to an appreciable extent. Nourse, of St. Bartholomew's, was among the first to deliver lectures at his private house, whilst in 1714 it was notified that "Mr. William Cheselden (soon after surgeon to St. Thomas's Hospital) did frequently procure dead bodies of male-factors from the place of execution and dissect them in his own house, so that it was more difficult for the beadles to bring away the Company's bodies."

Other sources of supply had now to be exploited, and it is significant that as early as 1717 an entry appears in the records of St. Saviour's Vestry that "Wm. Dodd, late gravedigger, is charged with inhumanity and guilty of *malepractices* in carrying away the *corps* of persons buried, and disposing of them to Surgeons in order for dissection. Ordered thereupon, That said Wm. Dodd be prosecuted at the next assizes with the utmost severity the law shall direct." From this time onward the trade of the "body-snatcher" became more and more firmly established.

In 1745 the Surgeons broke away from the Barbers and established themselves in the Hall in Old Bailey, their headquarters until they removed to Lincoln's Inn Fields. The last scene of Hogarth's "Four Stages of Cruelty" represents the ultimate fate of the St. Giles's charity-boy, Tom Nero, who has been hanged for murder; and an early commentary upon it is interesting from the light it throws upon the estimation in which the surgeon of that day was held:

"From the place of execution the murderer is brought to Surgeons' Hall, and is now represented under the knife of a dissector. This venerable person, as well as his coadjutor who scoops out the criminal's eye, and a young student scarifying the leg, seem to have just as much feeling as the subject now under their inspection; for frequent contemplation of sanguinary scenes hardens the heart, deadens sensibility and destroys every tender sensation. Our legislators, considering how unfit such men are to determine in cases of life and death, have judiciously excluded both surgeons and butchers from serving on juries." The allusion here is apparently to an early regulation by which the barber-surgeon was exempted from serving "as constable, or on the nightly watch, *on juries*, inquests, attaints or recognisances."

The same commentator remarks that the President, in the engraving, "much resembles old Frieake who was the master of Nourse, to whom the late Mr. (Percival) Pott was a pupil."

The control exercised by the Company over the actions of its members gradually declined; the surgeons established their freedom to pursue their studies independently; and the business of the "resurrectionists" flourished in proportion. Besides raising the ordinary material for dissection, their attention was called from time to time to the death of persons of exceptional physique. A note in the *Daily Advertiser* of August 16th, 1749, regarding a "resurrection" in Shoreditch parish, is quite characteristic of the period. "Yesterday it was said that Topham, the Strong Man, had, the night before, with the assistance of some surgeons, got the better of his grave, though some eight feet of earth had been laid on him."

The story of Charles Byrne, or O'Brien, the Irish Giant, is better known, for his skeleton is to be seen in the Museum in Lincoln's Inn Fields, and is represented in the background of Sir Joshua Reynolds's well-known portrait of John Hunter. Byrne was uncomfortably aware that his great height, 8 ft. 4 in., had attracted Hunter's notice, and, before his death in 1783, arranged with certain fishermen that his body should be taken out into the Irish Channel and dropped into the sea. When the time came, however, Hunter, by means of a £100 note, persuaded the scrupulous fishermen to exceed their instructions; so that they put the body overboard, indeed,——but with a line attached to it. And the great surgeon had thus the satisfaction of adding the great skeleton to his collection.

Now and again persons of a different quality of celebrity had their rest disturbed. Jonathan Wild, the notorious criminal thief-taker, was interred after execution in St. Pancras churchyard, "but a few nights afterwards the body was taken up, for the use of the surgeons as it was supposed. At midnight a hearse and six was waiting at the end of Fig Lane, where the coffin was found next day."

It has been said, too, that Laurence Sterne was removed from his lonely grave to the dissecting-table.

The parish records inform us that at this date the resurrectionists were at work in the Borough. In 1786 a reward of £5 was offered for the apprehension of four men who had dug up a body in the burying ground in Red Cross Street and taken it away in a coach. This was the "Cross Bones" ground that originated as a place of unconsecrated sepulture for the inhabitants of the Stews on Bankside. Two years later it is observed that "the east side of the burial ground next the common sewer is open and easy of access to those who make an infamous and detested practice of stealing dead bodies."

By this time Astley Cooper had already come to London, and, after a brief and uncomfortable association with his uncle, William Cooper, the Guy's surgeon, had secured the transference of his articles of apprenticeship to Henry Cline of St. Thomas's, and had settled down to the earnest study of anatomy that was the basis of his later fame. It was in these years that "his adventurous nature found scope in many a night expedition with the body-snatchers," when he gained experience that was of the greatest value to him at a later date when, as the director of a great anatomical school it was necessary to arrange for the supply of subjects for dissection.

In the summer of 1793 he was appointed Lecturer on Anatomy to the College of Surgeons, and it was his duty to dissect, publicly, in the yard of Old Bailey, where the Surgeons' Hall was then situated, the bodies of criminals who had been executed in that prison. After three years he was succeeded in this post by Thomas Blizard of the London Hospital in whose time the College removed from Old Bailey. It is recorded on December 6th, 1796, that "Francis Dunn and Will Arnold were yesterday executed for murder and the first malefactors conveyed to the New Surgeons' Hall in the Lincoln's Inn Fields. They were conveyed in a cart with their heads supported on tea-chests for the public to see."

The dissection of executed criminals at the Surgeons' Hall afterwards became the merest formality when, in the presence of the City Marshal, a superficial cruciform incision alone was made upon the chest of the subject in order to satisfy the requirements of the law, before the body was handed over to one of the teachers of anatomy.

Astley Cooper's association with body-snatching was not confined to human subjects alone. After he had moved into the house at 12, St. Mary Axe, whence Cline had removed to Lincoln's Inn Fields in 1797, he occupied himself with Vivisection and Comparative Anatomy in addition to his regular work. In a hay-loft attached to the house were kept as many as thirty dogs, besides other animals—"the subjects, or about to become so, of experiments" for physiological illustration or investigation; and the servants, and others connected with the establishment, were engaged to maintain this supply by stealing dogs at half-a-crown a head.

In a large warehouse on the premises, a great deal of dissecting of different kinds was carried on. Astley Cooper "entered into terms with the persons connected with the Menagerie at the Tower, to send to his house all the animals which died in that Institution."

In the course of the year 1801, an elephant, which had been one of the principal features of the exhibition, died. He, accordingly, hired a cart, in which, after a considerable degree of exertion, the elephant was deposited, and afterwards covered with a large cloth, in order that it might attract as little notice as possible on its way. All efforts to get it into the out-house proved unavailing, and it was found necessary to leave it lying exposed in front of the building within the outer iron gates.

During the efforts to remove the carcase into the dissecting-room, a large mass of persons collected outside the gates, watching the proceedings through the iron railings. The obstruction this crowd caused in the thoroughfare of St. Mary Axe was so great that it was found necessary to cover up the apertures between the railings by throwing a carpet over them, and to move the body of the elephant as far as possible out of the view of those who were passing in the street.

He "was thus compelled to dissect the animal in the open air, and finding himself, from its enormous size, unable to perform the task alone, he invited several students from the hospital to assist him. Here for some time they worked together, being barricaded from the observation of the public; nor did they cease their operations until they had examined every structure to the very bones. These latter were carefully prepared, and formed the skeleton which, even up to the present day, may be seen in the Museum at St. Thomas's Hospital."

R. M. W.

(To be continued.)

Reviews, etc.

Books for review should be addressed to The Editor, Gazette Office, Guy's Hospital, S.E. Their price should in every case be stated.

How to Diagnose Small-pox. By W. McC. Wanklyn. Demy 8vo. (Smith, Elder & Co.) 3s. 6d. net.

The fact that recent legislation in regard to exemption from vaccination has rendered fresh outbreaks of small-pox in the future more than probable, is quite sufficient warrant for the publication of this book. Moreover,

since delay in recognition of cases is one of the most important factors in the spread of the disease, any work which deals thoroughly with its diagnosis is especially likely to be valuable. When, further, the author sets out to prove the contention of another authority on small-pox, who maintained that "it is, perhaps, of all diseases, that in which a certain diagnosis can be arrived at in almost every case," and is sufficiently lucid and emphatic to succeed in giving the reader greater confidence in his own competency to deal with possible cases, one cannot help feeling that the volume is something of an acquisition. The book, which is the outcome of twenty years' experience of small-pox, is well arranged and illustrated.

Studies in Small-pox and Vaccination. By William Hanna, M.A., M.D., D.Ph. (Published by John Wright & Sons, Ltd., Bristol.)

As a treatise on the relationship between vaccination and small-pox this is a very valuable production. The work is based on observations made on a large number of cases which have occurred in the city of Liverpool during the last ten years. The subject is approached from several different and extremely interesting points of view, and the deductions to be drawn are made the more clear by a glance at the numerous tables and photographic plates with which the book is illustrated. The book deals with the value of vaccination in early life, with special reference to its modifying action on the disease contracted later at different ages; the value of vaccination at different stages of the incubation period and its value subsequent to the appearance of the rash.

Some original observations are also made on the relationship between total scar-area, age of patient, and severity of symptoms.

The whole work is admirably arranged and the summary of conclusions adds greatly to its completeness. We can thoroughly recommend it.

Diseases of the Skin. By David Walch. Demy 8vo. (Baillière, Tindall & Cox.) 6s. net.

The advances which have been made of late years in the study of skin diseases necessitate constant additions to the literature. The present volume is a concise handbook dealing with all aspects of dermatology, omitting little of importance, and having due regard for the findings of recent research. It is not intended to be exhaustive, but rather to supply essentials for practitioners and students. One fault peculiar to many medical publications, and particularly obvious in those dealing with diseases of the skin, we cannot refrain from noticing; it is the method of illustration. Photographs, however good, are practically valueless as a means of depicting skin lesions. The photographs in this volume are, perhaps, above the average, but most of them could have been omitted without detriment to the value of the book.

Volumetric Analysis, for Students of Pharmaceutical and General Chemistry. By Charles H. Hampshire, B.Sc. Lond., A.I.C., Demonstrator of Chemistry at the School of Pharmacy of the Pharmaceutical Society, London. (J. & A. Churchill, 1912.) Pp. viii. + 104. 3s. 6d. net.

This book was originally intended for pharmaceutical students, but has been enlarged so as to render it suitable for a general course. The special feature which led to its compilation is still the most valuable feature of the book, and for those who are likely to be called on to make volumetric analyses of pharmaceutical products no better text-book could be suggested.

First Aid to the Injured and Sick. An Advanced Ambulance Hand-book. By F. S. Warwick, B.A., M.B. Cantab, etc., Major, R.A.M.C. (i.). A. C. Tunstall, M.D., C.M., F.R.C.S., Ed., Major, R.A.M.C. (i.). Eighth edition. (Bristol: John Wright & Sons, Ltd.) Paper, 1s. net.

This is the most comprehensive "first aid" manual we have seen, but we doubt if anyone, who has not had a long course of practical work, could even attempt to memorise—far less understand—all that is put before him in the chapters on physiology and treatment. Still, the manual would be an excellent companion for any first aid student to refer to. The whole book is most complete and up to date, and the illustrations and text in the chapter on "Transport of Sick and Wounded," are most praiseworthy, and would be of great use to any R.A.M.C. or O.T.C. men.

Manual for Women's Voluntary Aid Detachments. By P. C. Gablett, M.R.C.S., Lieut-Col., I.M.S. (retired). Second edition. (Bristol: John Wright & Sons, Ltd.)

This book deals mainly with the treatment, and the preparations for treatment, of wounded men who have been sent back as far as "clearing hospitals" from the field hospitals. It is essentially a practical book, and is an excellent manual for women who have some knowledge of first aid, and wish to extend their knowledge of hospital nursing and improvisation.

Annual Report of the Royal Dental Hospital of London, 1912. (John Bale, Sons & Danielsson, Ltd.) 5s. net.

A very interesting volume containing thirteen original communications, reports of cases from the hospital clinic, hospital and school notes, and other information of more immediate interest to Royal Dental men. Of the reports one of the most interesting is that by Dr. Dudley Buxton on "Prolonged Anæsthesia in Relation to Tooth Extraction." It would be both interesting and instructive to have Dr. Dudley Buxton's views on "Prolonged Anæsthesia in Relation to Conservative Work."

The printing and binding of the volume are alike excellent, the only thing calling for adverse criticism

being the advertisements inserted at the end. The excuse cannot be offered that they are even publishers' announcements; and it seems a pity that books of this type are used as a medium for advertising. Shelf-space is too valuable.

British Red Cross Society Nursing Manual. By James Cantile, M.A., M.B., F.R.C.S. (Cassell & Co.) 1s. net.

A most instructive and useful book. While specially written for field or camp work, it cannot fail to be attractive to anyone interested in nursing. It could also be highly recommended as a book for the home, containing many useful recipes for sick room cookery as well as hints and advice lucidly described for the comfort of invalids which could be carried out by those other than trained nurses.

Physiology Made Easy. By Lucy Brooks. (The Scientific Press, Ltd.) 1s. 6d. net.

Clear and concise so far as it goes, but as the preface admits, but a "ground work," and perhaps on this account of doubtful value to probationers who might be satisfied with obtaining a superficial smattering of facts.

Elements of Anatomy and Physiology. By W. Bernard Secretan. (The Scientific Press, Ltd.) 2s. net.

Described as being especially adapted for nurses. For the training of the modern nurse such an elementary book seems hardly worth while. Perhaps in small hospitals where there is no preliminary training school and only periodical lectures given it may be considered sufficient, but certainly has little to recommend it to those who aim at a certificate of any value.

Medical Electricity and Light: a Text-book for Nurses. By Dr. Ettie Sayer. (M. F. Beardshaw.)

Dr. Ettie Sayer has set herself no light task when she tries, in a small text-book, to explain medical electricity and light to those who are called upon to apply it, without having previously made a study of that branch of therapeutics. Dr Sayer has endeavoured to supply in a few chapters a course of lectures in electricity similar to that which nurses receive during their general training in medical and surgical nursing, which renders them capable of administering the prescribed treatment in an efficient manner.

This hand-book, with its very helpful diagrams and illustrations, will be of great assistance to the average nurse at the beginning of her experience in electrical treatment, for it is a supplement to the verbal explanations given her as she enters upon her new work, and one to which she can always refer, if she fails at first to grasp the workings of an apparatus.

One regrets that Dr. Sayer did not go into greater detail on the subject of X-rays as applied for curative purposes, and also that her chapter on ionization is so cursory. If she had left more of the technique of high frequency and statical treatments to the common sense of the nurse, and given her in place of that more practical points on work which has a far greater future before it, the nurses who have undoubtedly learnt much from this small text-book would have still more reason to be grateful to the author for supplying so efficiently a much felt want.

Essentials of Fever Nursing. Maitland. (Scientific Press.) 1s.

An eminently useful little book which should be in the possession of all who are taking up fever nursing. It only costs 1s., is printed in clear type, and can be easily carried in the pocket. The information is most clearly and concisely expressed, and is distinguished by practical common sense, which should appeal to all nurses. For example, in the chapter on diphtheria, the author, in emphasizing the importance of a recumbent position, remarks "It is better for the child's heart that he should be allowed to sit up quietly than to lie down fretfully." The directions for disinfection are admirable. Altogether, a book to be heartily recommended.

Lewis's Pocket Case Book.

We have received from Mr. H. K. Lewis a new Pocket Case Book designed for the use of students and practitioners.

The book is neatly bound in limp cloth and the page measures 8 in. by 5 in. It is arranged for 25 cases; four pages are allotted to each case and the headings are arranged for the record of the usual particulars, including Personal History, Family History and Present Condition.

There are also diagrams for the marking of physical signs, space for Diagnosis, Prognosis, and extra space for the record of Treatment and Progress, including a miniature temperature chart which should be very useful.

The price is 1s. 6d. net.

Appointment.

Civil.

Whitworth, William Cuthbert, M.R.C.S., L.R.C.P. Lond., has been appointed House-Surgeon to the Royal Cornwall Infirmary, Truro.

Death.

ENDSALL.—On June 17th, at 143, Croxted Road, Dulwich, Raymond C. Viner Endsall, M.B., B.S. (late of Guy's, N. Z. Ship. Co., and Union-Castle Co.), elder son of Chas. Viner and Alice M. Endsall, in his 32nd year. Interment, Norwood.

G. T. M.

GUY'S HOSPITAL GAZETTE.

VOL. XXVII., No. 657.] AUGUST 30, 1913. [SIXPENCE.

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Passim.

PROFESSOR HARVEY CUSHING in his eloquent and stimulating Address on Surgery at the International Congress of Medicine, laid particular stress on two points. The first one was that recent developments in medicine and surgery were tending to bring the physician and surgeon closer together again, making them colleagues and not rivals as they threatened to become some years ago in the exuberance of the surgical renaissance. If this be so, and we have no knowledge one way or the other, since any but the most recent years are unknown to us, it is all for the good both of medicine and the profession—not always, to the short-sighted at least, the same thing. If the philosophic observer can already see the two great wings of the profession converging on one another, perhaps our dream that one day the physicians will regularly see their cases operated upon, and still more that surgeons will go to see and learn from physicians as well as from fellow surgeons, is not altogether a Utopian one. The plea that is sometimes put forward that men can learn all that is necessary from the writings of their opponents, is in our opinion totally inadequate. With most of us the appreciation of the *exact* meaning of words is so deficient that it is only a few great masters of language who can faithfully convey their meaning to us. As an example of what we mean let anyone ask himself how often the written description of any morbid condition has conjured up a true picture of the disease. We feel convinced that the only firm ground on which to conduct either medical teaching, or more especially controversy, is the clinical one. If some of the great protagonists were to meet one another more frequently, actually by the bedside of the patient, more progress would be made in a month than is now made in a year.

THE other point upon which Professor Cushing laid emphasis was the necessity for closer relationship between, and more intimate knowledge of, workers in same or even in different fields. He attached considerable importance to the results of visits to other clinics, not only as helping us to learn new truths and theories but, what is almost as essential, providing us with new or different standpoints from which to regard familiar conditions.

AND in this connection the article on Colonel Elliot's Eye Clinic in Madras, which we published last week, serves to emphasize a change which is gradually appearing in the localization of medical progress and teaching. Fifteen or twenty years ago it was sufficient for an Englishman desirous of seeing the best work outside his own country, to visit the Universities of Germany, France, and Austria with the comfortable feeling that that being done he could say, "I have seen the best." In recent years, however, a change has appeared—for the surgeon it is no longer sufficient to cross the Channel to Berlin and Prague in pursuit of knowledge; his face must be turned to the

west as well as to the east, and Rochester and Chicago must be visited before he can feel that he has seen all that is best in modern surgery. And now Captain Reinhold would have the ophthalmologists push further east than Vienna even, and come to Madras if they would see all that is good in ophthalmic surgery. Who knows but in another twenty years we shall go to Pekin to study orthopædics and to Buenos Ayres for laryngology?

MEANWHILE there is still much to be learned at home by watching the work of colleagues and contemporaries. Professor Cushing was speaking chiefly of surgeons but his remarks apply equally to physicians and general practitioners. Closer communication between the staffs of hospitals, both individually and collectively, would be of considerable benefit in raising, if not perhaps the standard of knowledge, at least certainly of treatment, both as regards operative technique and drug therapy. There was much to be said for the old custom; when the surgeons gathered in the old theatre and discussed and criticized the diagnosis and treatment of their patients. And even nowadays much might be done, especially in the utilization by the general surgeon of the peculiar knowledge and skill of his specialist colleagues. How painfully often does one not see cases in the general wards undiagnosed or misdiagnosed for want of the special knowledge or special apparatus which was easily available.

NOR are signs wanting that there is a change for the better in this respect occurring in London. The recently established surgical At Homes, of which we gave an account some months ago, are a move in the right direction, and also, we believe that here in our own hospital there is an increased tendency, especially among our younger surgeons, to watch and learn from their colleagues. Much remains to be done, however, before we even approach the ideal.

THE present arrangements for the dental treatment of ward patients do not seem at all satisfactory. Very rightly and properly they are not supposed, even if able, to go down to Out-Patients for the extraction of the necessary teeth, nor are they allowed to have the teeth taken out in the Conservation Room. The only alternative is to pull the teeth in the ward with the patient on a chair or in bed. It is by no means easy to manage an anæsthetized patient on an ordinary chair, and extraction under gas in bed is not only unsatisfactory, but is positively dangerous and almost unjustifiable except in cases of necessity. The difficulty, it seems to us, might be easily overcome by the provision of one or two dental chairs on both the medical and surgical sides. They might be placed in the anæsthetic rooms without interfering with the general arrangements of the theatres.

APPARENTLY there is trouble ahead for others besides Sister Cornelius and the house-surgeons who take-in to that ward. At any rate the editor of the "St. Mary's Hospital Gazette" has been looking forward into the future and foresees great trouble when the operative treatment of simple fractures becomes the rule. Already, he says, the waiting list for non-urgent surgical cases is deplorably long, what then will happen when all the simple fractures remain for weeks filling up the beds. Let him not despair. Given a good sister and the not-too-tender conscience of a take-in H.S., beds will appear as if by magic.

THE Guy's team were successful in carrying off the Lawn Tennis Challenge Cup offered by the "Nursing Times" for competition among the nursing staffs of hospitals in the London area. The match was played on July 25th, at St. Marylebone Infirmary against Qneen Mary's Hospital, Carshalton. This is the second year in which the competition has been held, and on both occasions Guy's have won the Cup. Congratulations to the winners, Nurses Rowan, Ryan, Rolls, and Raven, on so worthily upholding the Guy's tradition of pre-eminence in all things, including sport.

As we go to press we learn that it is intended to revive the old custom of opening the Winter

Session with a dinner in the Students' Club. The date fixed upon at present we understand is October 1st. During the evening the names of the prize-winners for the year will be announced, and the successful men will be the guests of the Medical School. Tickets for the Dinner, price 3s. 6d. each, may be obtained at the Medical School Office.

We will publish fuller details of the arrangements in our next issue, but meanwhile would express a fervent hope that there will be a good turn-up of junior men. They are far too ready to believe that they are not welcome at these functions, whereas it is especially younger men who are wanted.

The Milward Fund.

SIXTH LIST OF SUBSCRIPTIONS FROM GUY'S MEN.

	£	s.	d.
Amounts previously acknowledged	165	18	6
Hugh Bennett, Builth	1	1	0
H. W. Bruce, London	1	1	0
Evan N. Davies, Pontyclun	2	2	0
E. J. Dunville, Exeter	1	1	0
B. B. Gough, Bristol	1	1	0
C. W. Greene, Rochester	2	2	0
E. S. Hall, Brightlingsea	1	8	8
F. W. Penfold, Rainham	1	1	0
M. H. Thornely, Major I.M.S. ... ... and £1 1s. a year for five years.	2	2	0
W. J. Tyson, Folkestone	0	10	6
Wilson Tyson, Lowestoft	1	1	0
W. A. E. Waller, Rugby	1	1	0

Particulars of the Fund can be seen in the Gazette of May 10th.

Further Donations will be gratefully received by the Hon. Treasurer, Mr. William Sheen, 2, St. Andrew's Crescent, Cardiff.

Pass List.

University of London.

First Examination for Medical Degrees.

Ba Thin, M.
Deacon, E. F.
Hinde, E. C.
Leblanc, F. R.
Lindsay, G. P.
Pritchett, H. N.
Young, F.

Second Examination for Medical Degrees.

Part I.

Berncastle, H. F. G.
Heckels, G. W.
Joffe, J.
Kidman, G. E.
Phillips, E. S.

The Resurrectionists.

II.

"*And your eyes*
A Doctor has bottled—from Guy's."
Bloudie Jacke of Shrewsberrie, Ingoldsby.

The story of the body-snatchers is no less concerned with the medical schools of London than with the surgeons, and it is necessary to explain what was their position at this period.

In addition to the two Royal Hospitals of St. Bartholomew's and St. Thomas's, both dating their origin some hundreds of years before the Reformation, five other general hospitals came into existence in the course of the eighteenth century, although several of them began their career in quite a small way as dispensaries. Westminster was started in 1719, five years before the completion of Guy's. A disagreement amongst the Westminster Governors in 1733 resulted in the secession of a certain number of them to found St. George's Hospital. In later years their schools have been closely associated, and the forthcoming removal of the two hospitals from their present sites promises a still more complete reunion between these institutions. The London was established in a modest fashion by the surgeon, John Harrison, and a committee in 1740, and was considerably enlarged eighteen years later. The Middlesex was opened as a general hospital in Windmill Street, near Tottenham Court Road, in 1745, set up an additional lying-in department shortly after, and removed to its present situation in 1755.

In no case was a regular medical school established in connection with any of these hospitals before the second half of the century; for, in the earlier period, those surgeons who taught anatomy delivered their lectures at their own homes or elsewhere away from the hospital to which they were attached.

William Hunter, "the first great teacher of anatomy in England," attended the Lectures of Nourse, of St. Bartholomew's, in 1748. "I attended as diligently as the generality of students do, one of the most reputable courses of anatomy in Europe. There I learned a good deal by my ears, but almost nothing by my eyes; and therefore hardly anything to the purpose. The defect was that the professor was obliged to demonstrate all the parts of the body, except the bones and vessels, upon one dead body. There was a fœtus for the nerves and blood-vessels; and the operations of surgery were explained, to very little purpose indeed, upon a dog. And in the whole course which I attended in London, which was by far the most reputable that was given here, the professor used only two dead bodies in his course. The consequence was that at one of these places all was

harangue,—very little was distinctly seen; in the other, the course was contracted into too small a compass of time, and therefore several material points were left out altogether."

William Hunter had, himself, begun to teach anatomy to a society of naval surgeons in 1746, in succession to Samuel Sharpe of Guy's. He was joined, three years later, by his brother who assisted him in the classes. John Hunter attended the lectures and operations of William Cheselden, of St. Thomas's, at the Chelsea Military Hospital; and, after Cheselden's retirement, entered as a surgeon's pupil at St. Bartholomew's. In 1754 he joined St. George's as a pupil; was appointed house-surgeon in 1756; and was full surgeon there, from 1768 till the time of his death, in 1793; and the medical school of St. George's was to a great extent his creation. He was always popular with the resurrectionists, and, unlike some of his contemporaries and successors, experienced little difficulty in obtaining an adequate supply of material from them. It should be mentioned that the story of his acquiring the body of Charles Byrne as related in the Encyclopædia Britannica differs from the version given in the first of these articles; it is there stated that the giant's body was captured before it reached the sea-shore, whilst his height is put at the more moderate figure of 7 feet 7 inches.

After Hunter's day the school of St. George's was less successful. At one time the students themselves had to exhume bodies for their own use; and afterwards they and the men from Westminster attended a private school of anatomy in Little Windmill, now Gerrard, Street, opposite the Haymarket.

The school of St. Bartholomew's owes its foundation to John Abernethy, one of the many famous pupils of John Hunter. He was apprenticed in 1779 to Sir Charles Blicke, then assistant-surgeon at St. Bartholomew's; and afterwards attended the anatomical lectures given at the London Hospital by Sir William Blizard whose demonstrator he became.

"On the death of Mr. Pott (in 1788), Mr. Abernethy became assistant-surgeon to St. Bartholomew's, and succeeded Mr. P. as lecturer on anatomy and surgery. Mr. Abernethy's class continued for a few years to be very small owing to Dr. Marshall, who had been long giving lectures in the neighbourhood. . . . On Dr. Marshall relinquishing his lectures, . . . Mr. Abernethy's class became much increased in number. . . . St. Bartholomew's Hospital, on the death of Pott, fell off in reputation as a school for surgery, and had not Dr. Marshall given lectures near it, it would have been almost deserted. It has, however, advanced with the fame of Mr. Abernethy and is now (1825) among the first in the metropolis."

Abernethy's classes were, at first, held in a house in Bartholomew Close, but later, as their popularity increased, in a theatre specially built for him by the governors, within the hospital.

Near each of the hospitals was a recognised house of call for the resurrectionists. That of St. Bartholomew's was a public-house, "The Fortune of War," only destroyed some ten or twelve years ago, at the junction of Cock Lane (of "ghost"-ly memory) with Giltspur Street.

The position is still marked by the little figure of a naked boy who now conceals beneath a coating of gold paint the legend that formerly adorned his thorax and abdomen: "This Boy is in Memory put up for the late Fire of London occasioned by the sin of Gluttony, 1666." This pleasantry was suggested to a seventeenth century humorist by the fact that the Great Fire started near Pudding Lane in Eastcheap and extended to Pye Corner in Smithfield; but the corner gained its name in earlier times from the nature of the comestibles sold there during the course of Bartholomew Fair. Wares of a very different character were there disposed of at the beginning of the nineteenth century. To a room behind the tavern were brought subjects to be laid upon benches duly labelled with the surgeons' names until the new owners came to claim them.

At St. Thomas's subjects were usually taken directly to the dissecting room. In the winter of 1801, however, there was some friction between the hospital porters and the resurrectionists, with the result that the latter were no longer permitted to carry bodies into the school by themselves when they arrived at inconvenient hours. Astley Cooper's permission was, therefore, obtained for them to deposit the subjects at night in the outhouse in St. Mary Axe until they could be removed by coach to St. Thomas's under the care of the chief dissecting room attendant, Butler. He was one day thus conveying to the hospital three large hampers when the coachman, guessing the real nature of the packages, pulled up at an inn in Gracechurch Street to seek advice. Whilst the matter was still under disscussion Butler escaped back to St. Mary Axe; and the bodies were then removed to the watch-house at the foot of London Bridge. Two hours later the Watchman of the Ward, calling on Mr. Cooper who disclaimed all responsibility, expressed his determination to carry his complaint to the Lord Mayor. Next morning Mr. Cooper called on the chief magistrate while he was still at breakfast, and explained matters before the watchman obtained a hearing. The Lord Mayor was, fortunately, broad-minded enough to recognise the necessity for obtaining bodies for dissection as well as the inadvisability of stirring up public feeling on the subject, and assured the surgeon that he would be no further troubled.

At times popular resentment against the resurrectionists made it necessary for some of the students to receive the bodies at their own houses before conveying them to the dissecting rooms in hackney coaches, whose drivers were not slow to levy blackmail when occasion offered. One student was thus in charge of a

subject on the way to his hospital when the coachman pulled up in front of Bow Street police office with the remark, "Sir, my fare to So-and-So is a guinea, unless you wish to be put down here." No other reply was possible than "Quite right, my man, drive on!"

After John Hilton had been appointed demonstrator of anatomy at Guy's, in 1828, in succession to Edward Cock, it not infrequently happened that bodies, arriving after the dissecting room had been closed for the night, were deposited in the cellar of the house in Maze Pond where "Anatomical John" was lodging.

Besides the schools attached to the great general hospitals there were several private institutions where anatomy was taught and dissection carried on in the earlier years of the nineteenth century. One of these, the Windmill Street School under the proprietorship of a Mr. Dermott, was conducted mainly for the benefit of pupils from St. George's and Westminster Hospitals. Sir Charles Bell, a member of the Staff of the Middlesex Hospital, and the author of the standard work on "The Anatomy of Expression," was at one time attached to the school in Windmill Street.

Two other famous private establishments were the Dean Street and the Blenheim (or Great Marlborough) Street Schools. The former was instituted in 1800 by Joseph Constantine Carpue in Dean Street, Soho, on a site afterwards occupied by the Royalty Theatre. Carpue was "a clever but very eccentric person, a very good anatomist," who for twelve years was staff-surgeon at the Duke of York's Hospital, Chelsea, but was never upon the staff of any of the hospital medical schools. He was known as the "Chalk Lecturer," from the facility and lucidity of his blackboard diagrams. He continued lecturing until 1832, when his school came to grief.

Joshua Brookes was the founder of the anatomical school at the foot of Blenheim Steps, Oxford Street, and a first-rate teacher. "He did not teach by coarse pictures and learning by heart the answers collected from reported College examinations, as do the genus of *grinders*." Brookes was most unfortunate in his dealings with the body-snatchers who revenged themselves by playing many dastardly tricks. On one occasion, irritated by his refusal to give them a gratuity of five guineas at the commencement of a session, they brought two highly decomposed bodies and left them by night in front of the lecturer's house, where they were stumbled over by a pair of young ladies. Popular indignation was so great that the house would have been destroyed and Brookes himself endangered but for the protection afforded by a detachment of police from the neighbouring Marlborough Street station. Again, when he desired to procure the head of a person who had died of some disease of special interest, the resurrectionists employed were reckless enough to remove the head alone, leaving the decapitated corpse exposed in the graveyard.

At another time Brookes was knocked up at night to receive a body done up in a sack. He kicked the the parcel down a short flight of steps towards his dissecting room, paid the messenger and dismissed him. A little later, hearing groans coming from the package, he opened it, and found a living man within. Whether, as the man alleged, an unsuccessful attempt at murder had been made before disposing of the body, or, as was more probable, it was a cunningly-planned trick to burgle the house, was never ascertained.

Another famous anatomy school was established some years later by Edward Grainger, a former pupil of the Borough schools. A summer course of dissections was first established in 1820 in a large attic up three pairs of stairs in St. Saviour's Churchyard, and in the autumn of the same year was removed to more convenient premises in Webb Street. Grainger made no attempt to rival Astley Cooper, whose lectures the Webb Street students frequently attended. Much of Grainger's success was due to his friendly relations with the resurrectionists from whom he often received bodies which were withheld from the larger schools in the expectation of obtaining a better price. It was in this fashion that the private teachers were enabled to compete with the medical schools of the hospitals where the supply of bodies was erratic, although the demand for them was steadily increasing. The Corporation of Surgeons, or, as it became in 1809, the Royal College, insisted on a knowledge of anatomy, and each student was required to produce a certificate of having attended at least two courses of dissection. A certain number of students contrived to evade this regulation, however, and the Society of Apothecaries, as yet, imposed no such restriction. Another advantage enjoyed by the private establishments lay in their summer courses; at the hospitals, at this period, dissection was only pursued throughout the winter sessions, and many students patronized the smaller schools during the months when their own dissecting room was closed.

Popular agitation at the evils of the body-snatching trade at length moved Parliament to appoint a Royal Commission to inquire into the whole business in 1828, and the Anatomy Act was eventually passed in 1832. By that date three other general hospitals had been established in London. The Royal Free was started in 1828; but it had no school until many years after. In the same year the medical school of the University of London was instituted as the outcome of a quarrel between Abernethy and Mr. Lawrence, and the students attended the practice of what was then the North London Hospital. Charing Cross was founded in 1831, mainly at the instance of Dr. Ben-

jamin Golding, a former student, and the historian of St. Thomas's. Both King's and Mary's arrived later still.

Before these times, however, the minds of surgeons and students alike were gravely concerned with this topic, as a passage from the *Lancet* report of the Anniversary Dinner of St. Thomas's and Guy's Hospitals, held on January 8th, 1824, will show. This was nearly, if not quite, the last of such dinners, for the Borough Schools separated in 1825, although the United Hospitals' Club, founded in 1828, still unites certain members of the two Staffs.

"Mr. Fitzwilliam sang a medico-comic song which was vehemently applauded. A stanza alluding to the scarcity of subjects in the following facetious vein,

"*Though Subjects be so scarce*
I'd scarce be one myself, sir.
Tol de rol, de rol,"

appeared to give particular satisfaction. It was rapturously encored, as they say in the play-bills."

R. M. W.

(*To be continued.*)

An Hour at Tamworth.

THE ancient town of Tamworth, which stands in the counties of Stafford and Warwick, is closely associated with the founder of Guy's Hospital.* There his mother was born, and thither, in her early widowhood, she returned from London, in 1653, when Thomas Guy, her eldest son, was eight years old. At its Grammar School he probably received his education till, at the age of 16, he went back to his native city to be apprenticed to a bookseller in Cheapside. Seventeen years later we find him contributing to the rebuilding of the Grammar School, and shortly afterwards founding his Almshouses for seven women, to which, fourteen years later, he added accommodation for the same number of men, whilst nine years afterwards (in 1701) he erected a Town Hall at his own cost. For thirteen consecutive years (from 1695 to 1708) Guy represented Tamworth in Parliament.

The Castle owes its origin to Ethelfleda, the brave daughter of Alfred the Great, and there still remains a fine piece of Saxon herring-bone stone masonry in its curtain wall. It was bestowed by William the Conqueror on Robert Marmion, the Royal Champion, whose younger son, William, became the first dean of the parish church, but the family became extinct in the time of Edward I.

The church, which is partly Norman, contains a tablet to Samuel Knight and his wife Judith, who was great-grand-daughter of John Voughton, brother of Thomas Guy's mother. The tower of the church possesses a curious and perhaps unique feature in a double, spiral stone staircase, arranged like the scala vestibuli and the scala tympani of the ear, both scalæ communicating with the roof, but one of them opening below into the interior of the church and the other into the churchyard.

Guy's Almshouses have just now been demolished in order, out of the accumulated funds, to erect more commodious ones, wherein each inmate will have more than a single room, as heretofore, to live in.

The picturesque Town Hall still stands, and in front of it is placed a bronze statue of Sir Robert Peel, who entered Parliament a century after Guy left it, and represented Tamworth from 1830 to his death in 1850.

It has been said of this great statesman that "no man ever undertook public affairs with a more thorough determination to leave the institutions of his country in an orderly, honest, and efficient condition." May it not be said, with equal truth, concerning the generous founder of our alma mater, that no man ever undertook so great a labour of love with more thorough determination to leave his work in an orderly, useful, and efficient condition? And may we not, with just pride, add that no hospital and medical school has ever had better or abler support from its lay managers, nor more enthusiastic loyalty from its medical staff and students than Guy's?

R. J. P. S.

*See Wilks and Bettany's Biographical History of Guy's Hospital.

Change of Address.

Roy Ellis, L.D.S., from 14, Hauteville Court, Stamford Brook, W., to 14, Clavering Avenue, Barnes, S.W. (Private Residence). Business addresses: 77 and 79, King Street, Hammersmith, W.; 6, Shepherd's Bush Green, W.; 41, St. John's Road, Clapham Junction, S.W.

S. Hanreck, L.D.S., from 25, North End Road, West Kensington, to 22, Carfax, Horsham, Sussex.

A. L. Saul, M.R.C.S., L.R.C.P., L.D.S., from Benoni, to Hamilton's Chambers, Church Street, Pretoria, Transvaal.

H. M. M. Woodward, M.R.C.S., L.R.C.P., from St. John's Hospital, Lewisham, to 15, Cavendish Place, Cavendish Square, W.

CORRECTION.

A. J. Cleveland, M.D. London. The correct address of Dr. Cleveland is Stanhope Lodge, 13, Thorpe Road, Norwich, and not as hitherto shewn in "Blue Book," etc.

Gazette Special Pathologist.

V. J. H., WESTCLIFF-ON-SEA.—This endometrium shows no evidence of a malignant growth. It consists of the usual glands and cellular stroma and is very vascular, as if it were in a condition of chronic endometritis.

PATHOLOGIST.

Hypertrophic Rhinitis and Hyperostosis of the Superior Maxilla.

AN UNDELIVERED[1] CLINICAL LECTURE BY T. B. LAYTON.

Gentlemen,—It is very easy to say that a person has an "hypertrophic rhinitis." It is much harder to know exactly what one means by the term, and harder still to know exactly what form of treatment will be the best in each separate case. For we have within the nose two tissues to deal with, the mucous membrane and the osteo-cartilaginous framework which supports it; and if we are loose in our nomenclature it is easy to use the word hypertrophy for any swelling.

We may therefore define a "hypertrophic rhinitis" as being a general swelling of the mucous membrane which is neither transient in character nor due to any specific general disorder, nor secondary to any local inflammatory lesion. But if our definition is a series of negatives we must enumerate those conditions which are not the disease in order that we may by the process of exclusion recognise those cases which are suffering from it.

First, then, a large number of persons suffer from a chronic swelling of the mucous membrane secondary to some local inflammation. This latter may be sinus disease with suppuration, or an ethmoiditis giving rise to polypi but without suppuration, or it may be secondary to a pharyngitis which in its turn is secondary to carious teeth; indeed, a vicious cycle may have been set up from some original nasal obstruction which has led to mouth breathing, to pyorrhœa, to pharyngitis, and so on to rhinitis, which accentuates the original nasal obstruction. But whatever the cause of this rhinitis the mucous membrane is bright red, is shiny on the surface with a sticky secretion, and appears more to be affected on the lateral wall than on the septal one.

In other persons, again, a slight deviation of the septum to one side may cause it almost to touch the inferior turbinal on this side, so that the casual observer thinks that this is hypertrophied; in such a case the turbinal on the concave side actually is hypertrophied, yet is it not a hypertrophic rhinitis but rather a compensatory hypertrophy so that the nasal fossa on the concave side may not be too large.

In other persons again, the mucous membrane will swell as a result of a very small stimulation, or of a specific stimulation, which is innocuous to other persons; the best known example is hay-fever, where the mucous membrane swells from the irritation of the pollen of flowering plants and grasses. In some persons there is no need to seek the country to get the effect, the dust of London on a warm sunny day, or the dust of their work among flour or grindstones will produce it. In yet another class of patients no such irritating substance is needed, the mucous membrane will swell apparently without cause or with only so slight a cause as a change from the upright to recumbent position, a slight change of temperature, or an attack of indigestion.

When the nose is examined in any of these conditions, the mucous membrane is found to be swollen, so that it touches that on the opposite side, and a watery secretion fills up the spaces between the folds, yet are none of them "hypertrophic rhinitis"; they are rather reactions, normal or hyper-normal, of the mucous membrane to substances which would be nocuous to the respiratory mucous membrane. Dr. Leonard Hill and Mr. Muecke[2] have recently drawn attention to this function and its importance in relation to the hot air of stuffy rooms.

There remains a class of patients with nasal obstruction in whom the mucous membrane is found entirely to fill the nasal fossa, but is not red nor œdematous, nor slimy, it secretes a clear watery fluid but is pink or almost grey in colour, and the front end of the inferior turbinal protrudes forwards towards the anterior nares so that the uninitiated mistake it for a polyp; from this it is distinguished by the probe which will not pass all around it as around a polyp but becomes stopped on the outer side where the turbinal is attached. On looking carefully the mucous membrane covering the septum is seen to share in the condition and to be swollen as well as that over the turbinal to an extent greater than it is in the other conditions which we have considered.

There are still two lesions from which this must be distinguished, tubercle and syphilis.

1. In a recent copy of the Gazette Dr. Shaw wages war against the practice of delivering clinical lectures prepared rather for the printer than the theatre. Realising the soundness of this principle, why should not one hand over to our Editor our carefully-prepared clinical lectures before they are delivered?

2. *Lancet*, May 10th, 1913.

The former is not hard, it is a localised lesion on the septum or on the turbinal not a general swelling; it is tender and bleeds easily, the diseased area appears as a mass of nipple-like projections of granulations having an œdematous translucent appearance and a red-brown colour. The syphilitic rhinitis is more hard to distinguish, but it is generally covered by some secretion and has a few particles of crust upon it.

Now that we have our case of "hypertrophic rhinitis" what are we to do with it? Truth to tell it is hard to say; we may snip off a piece of inferior turbinal, but the process has a way of growing again as big as before. We may give iron with arsenic in increasing doses over a period of several months, but though I always give that, I am not sure that they improve, and that it is not that they discontinue to attend. Perhaps the best thing to do is to paint it all with adrenalin and cocaine to find out how much air-way there is when the mucous membrane is all shrivelled up, and then to pin this last down on to the bone with the cautery in the hope of retaining this air-way. I have used a spray of very dilute adrenalin solution, but am not convinced that it did much good. One thing we must not use is a spray of cocaine; as the disease is a chronic one, and we shall surely set up that worst of drug habits, the cocaine-mania.

But while the practical importance of these cases lies in differentiating them from the other conditions which we have mentioned, their interest lies rather in their relations to a series of conditions of which they form one end of a chain, and such advanced things as leontiasis ossea and osteitis deformans the other. The more advanced cases of "hypertrophic rhinitis" bear to one another a remarkable facial resemblance, which in a well-marked case is that of the South American Chaco-Indian—a peculiarly squat flat nose, which is not found to be unusually low, like that of the congenital syphilitic, but the appearance is due to its excessive breadth.

This breadth is due to the fact that the bones around the nasal fossa are affected in the same way as is the mucous membrane. A chronic enlargement of the nasal process of the maxilla is present, due apparently to a laying down of new bone on the outside of the old. Sometimes this hypertrophy appears as a localized mass on the nasal process of either maxilla, and it is possible that the case of symmetrical exostosis of the nasal process of the maxillæ figured by Sir Jonathan Hutchinson is such a case.[3]

3. Illustrations of Clinical Surgery, vol. I., p. 11.

These cases form the intermediate step between those of hypertrophic rhinitis and hyperostosis[4] of the superior maxilla. As we do not know the pathology of either we cannot say they are the same disease, we may indeed have the hyperostosis without the hypertrophic rhinitis, or the latter without the former, but the interesting and suggestive fact remains that in some cases the two are combined.

The hyperostosis may be present at any age from childhood to late in life. A young girl was in the hospital under Mr. Fagge early in the year, and Sir James Paget tells of a case in a girl æt. 15, in whom it had first been noticed at 7.[5] On the other hand there is the specimen in the Royal College of Surgeons in a man æt. 60,[6] and I have seen it in an old woman of that age or more. Of the former I will give here Sir James Paget's description.

"Two large masses of bone, of almost exactly symmetrical form and arrangement, project from the upper jaws and orbits, and have partially coalesced in the median line. They are rounded, deeply lobed, and nodular; nearly as hard and heavy as ivory; perforated with numerous apertures, apparently for blood vessels. They project more than three inches in front of the face, and an inch on each side beyond the malar bones; they fill both orbits, the nasal cavities, and probably the antra, and they extend backwards to the pterygoid plates. Part of the septum of the nose, and the alveolar border of the jaw, are almost the only remaining indications of a face. The disease appears to have begun in the superior maxillary bones, and thence to have spread over the bones of the face, similar disease in a less degree existing in the bones adjacent to the chief outgrowths. The patient, who was 60 years old, believed the disease had been 18 years in progress, and ascribed it to repeated blows on the face. He suffered much pain in the face, eyes, and head. His eyes projected from the orbits; the right, after suppuration and sloughing of the cornea, shrivelled; the left was accidentally burst by a blow."[7]

My own case was an elderly person whom I met one day in Battersea Park. She had not the orbital protrusion of this last case, but the width of the jaw could not have been less than what the College specimen shows. Her appearance was that of a person who had on either side the malar swelling which accompanies a black eye, and in addition the swelling of a dental abscess of the upper jaw. The lower eyelids were pushed up, almost closing the palpebral fissure, and giving her the look of one

4. The term leontiasis ossea is frequently used by speakers to include all these cases.—Proc. R.S.M., 1913, Laryng. Sect., pp. 44 and 70.

5. Surgical Pathology, 1863 edit., p. 542.

6. Spec., 1606, R.C.S.M.

7. Loc. supra cit., p. 541.

in whom a flood of tears had succeeded an overnight carouse. A chipanzee, now in the Zoo, which I suspect to be suffering from this disease, always reminds me of this old woman. She told me she had had it as long as she could remember, that it had never caused her any trouble at all except that her friends and relations insisted that it came from drinking too much beer, which she affirmed was a horrid libel. There was none of the pain in the face, eyes, and head, described in the other case. I gave her sixpence to cover the expense of a tram ride to our Out-Patient Department, but she never came, and I suspect that the coin went to help flood the profits of "the Trade," and that her friends' pathology has some foundation in fact.

It is, of course, a rare disease, and probably most cases which occur get some time or other into medical literature. Two cases were shown last year at the Laryngological Society, and the consensus of opinion seemed then to be that they should be left alone; some, however, were for removing the jaw while the disease is still limited, and this was suggested long ago by Sir James Paget. The difficulty would be, however, to find the case where it is so limited, for in the early cases that I have seen, the swelling had already affected the palate to its mid-line.[8]

They have, however, some practical bearing, for they must be diagnosed from other swellings of the upper jaw. We may contrast them on the one hand with the enlarged jaw of acromegaly, and on the other with a cyst arising within the jaw from an unerupted tooth.

Let us compare the three to the exact copy of the engraver, to the mimicry of the caricaturist, and the distortion of the infant's scribble, or of the cubist. In acromegaly the jaw is enlarged but retains exactly its shape if not its proportions; in the hyperostosis the shape is retained though masked by the overlying bone, it bulges into the inferior meatus, it fills up incisive and canine fossæ, and is seen extending across the palate to the mid-line; the dentigerous cyst as it enlarges has its own rounded shape which gradually replaces the original shape of the jaw. If these points be remembered and the nasal fossa and palate are both examined a diagnosis should not be difficult.

True, in the early stage with the disease limited to the outer side it might be hard to tell from an exostosis or early sarcoma. I have never seen an early sarcoma arising on the outside of the superior maxilla, but I do not think I should be long in excluding hyperostosis if ever I did; nor have I seen an exostosis in this region for they are rare tumours at all times, but I may again quote Sir James Paget[9] on this subject.

> "The exostoses and hyperostoses of nosology are not to be severally defined without artifice; but, in general, we may take this as a convenient, and perhaps a just, method of dividing them: namely, that those may be reckoned as osseous tumours, or outgrowths of the nature of tumours, whose base of attachment to the original bone is defined, and grows, if at all, at a less rate than their outstanding mass. Those which are not of the nature of tumours are generally not only ill-defined, but widely spread at their bases of attachment, and the additions made to them increase their bases rather than their heights or their whole masses."

As a matter of fact, exostoses do not seem to grow on the superior maxilla, with the exception of the symmetrical ones, to which I have already referred. Ivory exostoses grow on the lower jaw,[10] on the bones of the calvaria, and within the various accessory sinuses, but the sinus most often involved is the frontal air sinus,[11] and Mr. Hilton's case, growing from within the antrum,[12] is now said by Sir John Bland Sutton[13] and Mr. Davies-Colley to be an odontoma.

So much for the relation of these hyperostoses to localised tumours. Let us now consider their relation to those diffuse overgrowths of bone known as leontiasis ossea and osteitis deformans. The specimen in the College Museum shows the overgrowth extending on to the under surface of the sphenoid and on to the pterygoid processes. In one of the cases shown at the Laryngological Society exostoses of the external auditory meatus were associated with the maxillary overgrowth, and Mr. Pegler mentioned another case where more than one bone was involved. Such cases form intermediate stages up to the advanced cases described by Virchow.

8. Dr. Peters quotes Mr. Westmacott as having had a success lasting 20 years, and Mr. Wilkinson regretted having done an excessive operation in another case.—*Vide* Proceedings R.S.M., 1913, Laryng. Sect., pp. 44 and 70.

9. Loc. supra cit., p. 533.

10. The most important one, clinically, of which I know is No. 4325 of our Museum. By its causing ulceration over it, Mr. Bryant diagnosed it as a carcinoma of the gum, and removed it.

11. *E.g.*, R.C.S.M., No. 1603.

12. G. H. Reports, vol. I., p. 493. G.H.M., No. 4370.

13. Tumours, fifth edit., p. 226.

"Forcade's is probably the most noteworthy of these cases. This surgeon had a son who was quite well until his twelfth year, except for having had the small-pox. At that time his father opened a lachrymal sac at the inner angle of his right eye, which had long been discharging. There then appeared on the nasal process of the upper jaw a prominence the size of an almond, which so grew that in his fifteenth year it pushed together the nasal cartilages in such a way that the boy could only breathe through his mouth.

"After this the disease spread to the lower jaw, of which only the articular process and the alveolar margin remained normal; the upper jaw, the walls of the orbit with the cranium, the nasal orifices, the hard palate, and the zygoma, were involved and swollen up into one common lump. In his twentieth year his face was enormous. There resulted exophthalmos with short sight, difficulty of speech, general sluggishness, and he died blind, at 45, from consumption. The macerated skull weighed $8\frac{1}{4}$ lbs., the lower jaw alone over 3 lbs. Great knobby, lobulated exostoses, dense as marble, rose up from the upper jaw and other boundaries of the orbit. The cranial bones were studded with small smooth tumours crowded together and very sclerosed; the frontal and maxillary air sinuses had entirely disappeared. The rest of the skeleton was remarkable for the singular softness of the bones.

"Lastly, it is worthy of note that the facial muscles were hardly recognisable in section; they appeared fibrotic, and were fused with the periosteum and cellular tissue." (14)

To this, and similar cases, Virchow gave the name of leontiasis ossea,[15] as a sister name to that of elephantiasis cutis; he did not include the less marked cases under this name, but he recognised the transition on which I have tried to lay stress.

Osteitis deformans was first described[16] by Sir James Paget on a case which he had watched over twenty years. A similar hyperostosis of the bones is seen in this condition, but it differs from leontiasis ossea in that it leaves the bones of the face and involves only those of the cranial cavity and limbs, whereas the latter involves the skull and leaves the bones of the trunk and limbs.

Of the pathology of these things we know nothing. It is intimately bound up with two great problems of which we are as yet ignorant, the problem of the cause of tumours, and the laws which govern the growth of bone. We have seen above that the hyperostoses of the maxillæ are allied on one side to the innocent exostoses, and on the other to the diffuse diseases of bone; and as Mr. Cathcart has shown,[17] there is no essential difference between malignant and non-malignant tumours. These diffuse changes in osseous tissue are similar to what is seen in the soft tissues in hypertrophic rhinitis or to diffuse lipomatosis.

Osseous tissue, however, stands alone in having deposited in it inorganic matter. The deposition of this accompanies the growth of the tissue, and absorption of it must accompany the atrophy. In this problem of the growth of bone we must first decide what are the cells which deposit the inorganic matter. After having believed for many years that these were known Sir Wm. Macewen, in a recent publication[18] has thrown doubt on our ideas. But even when we know the cell we must learn the laws which make this cell deposit osseous tissue at one place and not at another. At least two factors seem necessary[19], some internal secretion whose circulation stimulates the osteoblasts to their function and also some mechanical stimulus which directs where this function should be exerted. Is it a disease of the osteoblasts? Is it a want or excess of the hormone? Or is it some abnormality of the mechanical stimulus which leads to these peculiar conditions.

And yet, again, it may be none of these. Sir William Macewen has suggested a new function for the periosteum. He describes it as—

"A 'limiting membrane' to the osteoblasts which may be extruded on to the circumference of the bone. As long as the periosteum remains intact the osteoblasts are thus prevented from being scattered among the damaged soft tissues and from entangling the muscular fasciculi, the tendons, and their connective tissue investments. When the periosteum is removed from the bone, the osteoblasts which are poured out intermingle with the injured soft parts, and do so most effectively when they have been disseminated by persistent movement, and when the soft parts and the muscular fasciculi have been torn and their interspaces filled with blood clot. These are the conditions best adapted for the dispersal, proliferation, and ultimate maturation of the extruded osteoblasts."(20)

14. Virchow, Geschwülste, 7te vorlesung, p. 22.

15. The College Museum has a good specimen and a plaster cast of another. They are at present unnumbered owing to the rearrangement of the Museum. Few students in London seem to realise the opportunity of learning surgical pathology which Mr. Shattock has given them in this new arrangement and the new catalogue.

16. Trans. Med. Chir. Soc., vol. LX., reprinted by the New Sydenham Society in 1901, vol. 173.

17. On the Essential Similarity of Innocent and Malignant Tumours, 1907.

18. The Growth of Bone, 1912.

19. Professor Keith, Museum Demonstration, April, 1912.

20. Loc. supra cit., p. 49.

Surgical pathology produces many conditions which bear out this idea of a function for the periosteum, and it gives us the added thought that perhaps these hyperostoses are a disease of the periosteum which has lost its power of limiting the action of the osteoblasts. They will then be looked upon as a condition in which the osteoblasts have run riot when the normal periosteal control has been removed from them.

These thoughts at present are but dreams, for we know not enough on which to build any solid theory; still we must look ahead and so even dreams may be of use.

The Recent Epidemic of Influenza in the Island of St. Kilda.

At midnight on Friday, 20th June, orders were received by the Admiral Commanding the Fourth Battle Squadron, then at Lamlash, in the island of Arran, to dispatch immediately a cruiser to St. Kilda for the relief of the inhabitants who were reported to be suffering from "an epidemic of Influenza and Pneumonia," and to be in urgent need of assistance.

There is no telegraphic communication between St. Kilda and the mainland, and the news of the condition of the inhabitants had been conveyed by the captain of a fishing vessel which had happened to call at the island. H.M.S. *Active* was ordered to raise steam at once for full speed, and proceed as soon as possible.

A reference to the Sailing Directions for the coast of Scotland showed the population of St. Kilda to be seventy-nine, and, although a ship of the Royal Navy is a floating community complete in all respects, the task of dealing with so large a number of acute cases was one calculated to exhaust rapidly the medical stores of a small cruiser.

An extra stock of drugs and medical comforts in the form of beef juice, Benger's food, tinned soups, etc., was therefore drawn from one of the other ships of the squadron, and three additional Sick Berth Stewards were also requisitioned.

At 5 a.m., on Saturday, the 21st, the ship left harbour and proceeded at full speed, 25 knots, to her destination.

St. Kilda is situated in the Atlantic and is the most westerly of the group of islands known as the Outer Hebrides, the nearest populated district being North Uist, 35 miles to the eastward, while the nearest port on the mainland is Tobermory, 115 miles away.

The island is very small, about two miles in length, by one and a quarter at its greatest breadth. It is composed of a series of precipitous cliffs, the highest being 1,300 feet, rising sheer up from the sea, except at one point at the S.E., where the land slopes down to the shore and provides the only landing place. It is on this slope that the village is situated. The village consists of a row of seventeen cottages, a church, a building called the post office, and the Manse—the house in which lives the Government schoolmaster, who also acts as Missioner.

The cottages, with one exception, are all built on the same plan. They are of stone with tarred felt roofs, and consist of two rooms about twelve feet square, and a third smaller apartment about eight by six feet, which is used in some cases as an additional sleeping place. Of the two rooms, one is used as a kitchen and general living space, the other as bedroom and parlour. The floors are of concrete or boarded, and all the cottages are quite dry; each living room has one small window and one fireplace.

Sanitation does not exist—the inhabitants defæcate where they wish, and refuse is thrown out around the cottages, and is scavenged, more or less, by a horde of mongrel collies. The water supply is from small streams from the mountain, is plentiful, and, before it reaches the village at any rate, quite clear. Until recently the inhabitants used, for lighting purposes, Fulmar oil, obtained by them from the Fulmar Petrel. Now, however, paraffin sent from the mainland is used. Peat is the only fuel.

Such is the exposed position of the island that for eight or nine months in the year—September to June—there is no communication possible with the outside world. Even in the summer months the Atlantic swell is, at times, so great that landing is impossible.

A very small portion of the ground is under cultivation, and there is not a tree or shrub in the island, nor is there any evidence of any attempt on the part of the inhabitants to cultivate flowers in or around the cottages.

The population remains fairly constant, illness is very rare, and crime stated to be unknown. I was informed that the statement found in various Encyclopœdias that there is a fairly high percentage of illegitimate births, is absolutely incorrect—only one such birth having occurred in the last twenty-five years.

Since all the inhabitants are natives, except the schoolmaster, who is from the mainland, and one woman who recently came from another island, it follows that they are very closely related.

One would expect to find evidence of degeneration in a community so small, and so closely interbred for so long a period, but from a physical point of view it does not appear to be present. Except in the case of one or two adolescents, the men are all healthy-looking and of a wiry type. The women are of good physique, and for the most part distinctly goodlooking. The children are all pale, but appeared to be free from symptoms of rickets. The older inhabitants speak Gaelic only, and in so short a time it was difficult to form an estimate of the mental standard, but most of the adults appeared to be intelligent, and well up to a peasant standard.

The industry of the island consists of the manufacture of coarse tweed and blankets, the collection of sea birds' eggs, of which there is an abundant supply, and the manufacture of Fulmar oil. This oil was formerly in great demand, but is not now greatly used except in some parts of Scotland, for the manufacture of soap.

The island possesses a Parliament, which is composed of the adult male villagers. This assembly meets frequently to discuss the nature of the work which is to occupy the men for the next few days—shearing, fishing, reaping, etc. The session is sometimes so prolonged that discussion occupies all the working hours of the day.

During the summer months there is a fortnightly service of steamers from Glasgow, and it was from one of these—the second visit this year—that the infection appears to have come.

No previous epidemic has been known since 1724, when the population was almost entirely wiped out by small-pox—four adults and twenty-six children only being left.

H.M.S. *Active* anchored in the small harbour at 3 p.m. on Saturday 21st. On our arrival none of the inhabitants could be seen, although all the cottages were in sight. Shortly after anchoring the captain and myself went ashore, and were then met at the small quay by two men, one of whom was Mr. MacArthur, the schoolmaster, or missionary, as he is called locally. He informed us that, with the exception of six, the entire population was suffering from an illness which had commenced suddenly on June 12th—nine days before our arrival.

The history of the epidemic, given by him, was as follows:—On 12th of June a steamer had anchored in the bay at dawn, and many of the inhabitants, as is the custom, had gone on board, and passengers (tourists) had landed and mixed freely with the inhabitants. The steamer sailed at midday, and late in the evening of the same day symptoms occurred in a few of the natives. On the following day large numbers were attacked, and the numbers increased daily until on the following Tuesday—five days later—the entire population (with the exception of the six already mentioned) was affected. The condition of the village during this week before our arrival must have been pitiable indeed. The six subjects who escaped the disease were all elderly, and unable to render any effective help to the sufferers.

I proceeded at once to make a house to house visit, and examination of the patients. In each cottage the conditions found were almost identical; all possible bed accommodation was fully occupied, those inmates not in bed, sitting huddled in shawls, or lying on the floor. In many instances there were three adults in one bed, and in some of the cottages seven or eight persons in one room. The one window in the apartment in every instance was tightly closed, and from this cause and the fumes of the peat fire the atmosphere of some rooms was appalling.

Except for tea and bread there appeared to be no food for the patients, though there was a plentiful supply in the village, the reason being that there was no one well enough to prepare it. Milk, of which there was a liberal supply, was not available, as for two or three days the cows had not been milked.

As a result of my detailed examination I formed the opinion that the inhabitants were suffering from an epidemic of influenza of the respiratory type, that there were no cases of pneumonia, and that the state of the village was: Sick in the acute stage (including men, women, and children), 45; the remainder of those who had been affected being convalescent. All the patients seem to have suffered from the same train of symptoms, varying in intensity in individual cases, and consisting of sudden onset of severe frontal headache, great pain in the eyes, burning skin, dryness of mouth and throat, with irritating, and persistent, dry cough, intense aching in the limbs, pains in all joints, and complete prostration.

When seen by me a great many were convalescent, but among those still in the acute stage, the above symptoms were well marked. Temperatures ranged from 99° to 104°. Physical signs were absent in lung areas, except in three or four cases in which signs of bronchitis were present.

Immediately after my examination the work of serving out nourishment and medicines began, the sick berth stewards very soon being busy issuing soups, beef tea, milk, and bread to each cottage.

Owing to the crowded condition of many of the cottages, I was anxious to find a place which could be converted into a temporary hospital, to which some of the cases might be removed. The only available place was the church, and permission was asked, and readily granted, for this to be taken over for the purpose. It is a small building about 35 ft. by 25 ft., with a small schoolroom attached.

A working party was sent ashore from the ship, all the forms, which take the place of pews, were removed except such as were required to support planking on which to place the bedding, and the whole building thoroughly scrubbed and washed down with disinfectant. Deals brought from the ship were then placed on forms along each side, covered with folded canvas, and mattresses and bedding, also brought from the ship, laid out. Good accommodation was thus provided for eight patients. The adjoining schoolroom was used as a dispensary, store, kitchen, and for the accommodation of the stewards. The cases for treatment in the hospital were brought down from the cottages by stretcher parties, the patients readily consenting to removal. A signalman was landed to communicate with the ship, if necessary, and the arrangements for dealing with the epidemic were complete. In the meantime the authorities in Edinburgh had organised an expedition consisting of a Medical Officer of the Local Government Board, an Inspecting Officer of the same department, and two Nurses, with a full stock of stores and provisions. The ship received orders by wireless telegraphy to proceed to Oban, 150 miles distant on Sunday, the 22nd, to embark this party and bring them to St. Kilda.

Leaving the stewards and myself in the island, the ship left at 4.30 a.m. for Oban. On making my round of the cottages later in the morning I found considerable improvement in many of the patients, and was able to add to my list of convalescents. In many cases, particularly among the men, some persuasion was necessary to convince them that they were better, and able to get up, so alarmed had they become about their condition. A few cases only presented serious symptoms, one, a girl of 16, suffering from persistent vomiting; a woman, who had bronchitis with marked dyspnœa and attacks of syncope; and a girl aged 13, who had suffered early in the epidemic and apparently recovered, but who now showed a recurrence of the

symptoms with a temperature of 104°. Examination in this last case revealed slight enlargement of the heart, and a long soft systolic murmur at the apex, traceable into the axilla, with reduplication of the second sound in the pulmonary area. Endocarditis was feared, but on the following morning the temperature was 99, and the child obviously much better, though the physical signs remained the same. Three cases among the women were complicated by the presence of chronic nephritis, and there were a few cases of bronchitis. During the day the stewards were again fully occupied distributing medicines, soups, beef tea, milk, bread, etc., by house-to-house visits.

At 10.30 that night the ship returned from Oban, bringing with her the Medical Officer, Dr. F. Dittmar, the Inspector, and two Nurses. Early next morning Dr. Dittmar landed with me, and after a visit to the hospital and all the cottages, took over from me the charge of all the patients. There was again a considerable improvement among the sufferers, and a much larger number than previously were able to be up and about. The nurses were able to do much valuable work among the women and children, and their presence and ready help were greatly appreciated by the inhabitants. While the ship remained at St. Kilda I assisted Dr. Dittmar in his work, and the stewards remained on shore to continue the work of distributing food and medicines.

On the morning of the 24th the condition of the men in the hospital had considerably improved, and they were removed to their homes, the hospital being dismantled, and the building once again brought to its proper condition of Parish Church. H.M.S. *Active* left the harbour the same afternoon, and so terminated an experience full of interest, and quite exceptional in service in Home waters.

When first the news of the outbreak of the epidemic was received one feared that the condition found might prove to be a very serious one. Typhus and typhoid were present in one's mind, and very great relief was felt when it was seen that both these could be excluded. There appears to be no doubt that the infection which caused the epidemic was introduced at the visit of the steamer on June 12th.

The visitation of small-pox in 1724 is the only other epidemic which has been experienced in the island. To the inhabitants such an outbreak as the present was terrifying, and fear seems to have exercised a very considerable influence in their condition, and, indeed, to those unaccustomed to any form of epidemic illness the vision of over 90 per cent. of the population suddenly stricken down with distressing symptoms must have been extremely alarming. The six elderly villagers who escaped the disease appear to have been terrified into inaction, and the condition of the whole village was one of helplessness; indeed, the only inhabitant who appears to have made any serious attempt to assist the patients was Mr. MacArthur, who, though ill himself, struggled about daily giving what help he could.

The effect of the introduction of infection to virgin soil such as this is of great interest, and in keeping with what one would expect. One may suppose that the infection was not of a virulent type, but in the event of the introduction of any form of infection more virulent the results might well be appalling.

R. W. B. HALL.
Staff-Surgeon, R.N.

Notes from Spain.

II. El Desencajonamiento.

The formidable word at the head of this article merely means "the unboxing," and refers to an interesting sight that occurs before the first great bull-fight of the season. It is the letting loose of the fighting bulls from the travelling cases in which they are sent from their respective ranches.

Last Sunday some friends of ours suggested a visit to the great bull-ring at Bilbao to witness this performance. For a peseta each we were admitted to the great building where we quickly clambered to seats on the shady side of the arena. We were a party of eight, including an English nurse who had just arrived from England to take charge of a patient of mine.

The great arena is capable of holding some 12,000 persons, but to-day there were only about 5,000 present. In the ring, up against the barrier, were ranged twenty-eight grey-painted cases looking uncommonly like bathing machines. In each case was a fighting bull. Presently two tame oxen with bells on their necks were driven into the ring. These were the decoys to conduct the wild bulls out of the place into the *corral* behind, where they are kept till they are wanted. Two men then climbed on top of the bull box at one end of the row and began pulling up the sliding door that faced the spectators. It was rather difficult as the beast within had his hind-quarters pressed against the door. A long pole was next manipulated through a hole in the roof, and presently out backed a fine black bull. For a moment he stood and gazed around him, tossing his head from side to side, and pawing the ground; then, as he saw the unknown in every direction, he charged vaguely hither and thither, until finally he ranged himself along-side of the tame oxen in the middle of the ring.

The process of unboxing was proceeded with until six bulls had been let loose. This number represented bulls from the same ranch.

It was curious to note the universal look of challenge in each bull as he faced about, and how at times he would charge towards the barrier as a head showed above the edge. One huge beast tried to jump the barrier but failed in the attempt, which created much excitement. In Madrid, at a bull-fight, I saw one smash the barrier with a charge. The impact must have been enormous. On the present occasion one or two bulls engaged in personal combat, their heads crashing together for a few moments and then separating as each recognised a playful brother of the plains.

The first lot were of a mixed colour, and among them was a magnificent red and white one. This fellow proved a tartar when the time come for conducting his "little lot" out of the ring into the *corral* beyond. The tame oxen led the way as the doors were thrown open. All trotted quickly out except one, the red and white *toro* before mentioned. He was not to be caught. He pulled up sharp near the barrier and faced about.

Whip cracks and shouts had no effect on him. A *chulo* several times entered the ring and tried to scare him in, but the result was the bull very quickly scared the *chulo* over the barrier as he charged towards him. The next thing to be done was to drive back into the ring all his companions and the decoy oxen. Again the signal was given and away trotted the herd into the *corral*, but the tartar still lingered behind amidst the jeers of the crowd looking on.

For fully an hour the little farce went on, as backwards and forwards the troop passed in and out of the ring, led by the decoys, but the wily beast did not get further than the entrance. He would look suspiciously at the "trap," and then trot back to the centre. Here he would invite attention, and receiving it in the shape of a man's waving arms, would charge in the direction of the enemy, who immediately took a hurried vault over the barrier. At last stronger measures had to be taken. These consisted of half bricks and biscuit tins hurled at the bull. The half bricks seemed merely like paper bullets to the massive beast. He tossed his head contemptuously as one struck him between the horns. The biscuit tins startled him, however. Certainly nothing seemed to hurt his thick hide. At last the performance came to an end, as a number of plucky helpers jumped into the ring, where, aided by a chorus of shouts from the wearied spectators, cracking whips and a shower of stones, they drove the obstinate "Number 6" from the ring with his tail between his legs!

The other bulls gave little or no trouble with their "unboxing," but there was always some excitement over the performance as they charged about, and engaged in personal combat before they recognized their brother bulls from their own *ganaderia*. There was one terrible moment, however, when an assistant thought all the five bulls had returned into the ring to bring out the troublesome "Number 6." The man stood shouting at the entrance to the *corral*. His back was turned towards the opening. Suddenly a black bull with head down came galloping into the ring. To the spectators, the enraged beast appeared charging full at the all unconscious man. A loud yell of horror came from the audience as they sprang to their feet. Then a miracle seemed to happen, for the bull dashed past the man and joined the other bulls beyond. The whole thing occurred in a moment, and it seemed extraordinary how the man escaped what would have been certain death, had the animal struck him in the back. Accidents, of course, occur from time to time, and to every bull ring there is a small hospital attached, with a completely equipped operating theatre.

I spent a whole morning going over the San Sebastian Bull Ring last year, and I was much struck by the completeness of everything in the hospital for emergencies. I have personally only seen one or two men slightly injured at bull fights, and the other day I happened to be at the hospital here when a patient, a renowned bull-fighter, was being removed after an amputation at the hip-joint for lacerated femoral artery in a fight at Bilbao. It was interesting to see with what respect he was regarded. All the patients who could hobble outside saw him off, and everyone saluted him as Royalty.

Sentimental writers tell you bull fighting will die out, but judging by all one sees and hears on the spot, there appears no sign of this. Rugby football is now a great attraction to delighted crowds here *all through the summer*, but after all, bull-fighting is the National Sport of Spain, and is likely to remain so.

Las Arenas, Bilbao, FREDERIC VICARS.
August 15th, 1913.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—ED., G.H.G.]

Renal Surgery.

"One soweth and another reapeth."

SIR,—I have read with much interest in your issue of August 2nd the account of Mr. Lucas's "triumph" in the surgery of the kidney, and which is again referred to in your last issue of the GAZETTE.

It carries me back in thought to my student days and to the practical part which I took as one of the earliest pioneers in this question. Mr. Lucas doubtless remembers it, since he happened to be one of the Vice-Presidents of the Pupils' Physical Society about the time I read my paper on "Nephrotomy and Excision of the Kidney" nearly forty-four years ago, viz., on Saturday night, the 9th October, 1869.

A brief account of its origin, etc., may, perhaps, be of some interest, even in these enlightened days. It came about in this way:—I was much interested in a bad case of renal calculus under the care of the late Dr. Habershon—such cases *then* were always treated in the *medical* wards—when it so happened that a man was brought in from the Borough, the result of an accident, suffering with *hæmaturia*. He had been knocked down by the shaft of a cab striking him in the lumbar region and on one side of the spine—had the blow been struck on the other side probably my paper would never have been written. He soon became *comatose* and died. At the post-mortem I was much struck by the fact that he had *only one* working kidney, and that was on the side which received the fatal blow and which ruptured the renal vessels on that side. Hence his *coma* and death. The other kidney had long before atrophied away to a mere useless remnant.

The coincidence of this case with the sad lot of the renal calculus man in the medical ward set me thinking a great deal; and, to "cut it short," resulted in the paper above mentioned and which, by-the-way, occupied me many months of preparation.

With more or less truth, perhaps, I was called a "lunatic and ought to be taken care of," "He's going wrong," etc., etc.—not by the members of the Staff, many of whom were not only interested in my venture, but from whom I received much kindly encouragement and advice. One was "dear old Sammy" (the late Sir Samuel Wilks) who, however, could not resist the temptation of nicknaming me "the kidney man!" Then, my dear old friend—the late Mr. Thomas Bryant—was very kind, and took me to a meeting of the Medico-Chirurgical Society to hear a paper by the late Sir (then Mr.) Thomas Smith, of St. Bartholomew's Hospital, bearing on the very subject in which I was already, and had been for so many months, engaged. But that paper was one of *suggestions only*, and *not* based on *experimental* research.

Again, there was my old friend, the late Mr. A. E. Durham, who was keenly interested in my undertaking, but a bit sceptical, comparing the question of

shock from any severe operation on the lower animals with the far more serious probabilities in the human subject, and so on. But these are only a few of the names of those whose kindness and the memory of whom will ever be very dear to me, and to very many other old Guy's men.

There was *no vivisection* restriction in those days. All my experiments, however, were always carried out with scrupulous care under chloroform, and with successful results. The chief thing which I did was to remove one kidney from each of several rabbits, and dear old Betts of the museum—he really was "one of the best"—mounted each specimen for me. Then at the end of three months I killed some of the animals, and, having removed the remaining organs respectively, got my old friend aforesaid to mount the specimens side by side to show the much hypertrophied condition—in each case double the natural size—of the organ which had for three months been doing double duty.

I operated upon a large number of rabbits (I do not remember how many—probably about thirty), but I reserved a dozen of them for special demonstration at the meeting of the Physical Society when I read my paper.

And, incidentally, here let me say a word or two on behalf of the generally-considered-to-be "hard-hearted" medical students of those days. Immediately after reading the paper I proceeded to kill one animal to show to the very large audience (the meeting was unusually well attended that night because of the novelty of the subject, and included some members of the Staff) that only one kidney remained (the other being on the table preserved in spirit, as already stated). All present being apparently quite satisfied with the demonstration, I was about to select another for the same purpose when from several members came the protest of "No! No!" and I was requested not to kill any more as they were all quite assured as to my success. It only went to show the *real* kindly-natured-man that the medical student was in those days. I never forgot it! The remaining animals I subsequently gave to the various officers employed about the hospital.

The scope of that paper, by-the-way, was *not* limited to "excision of the kidney," but was in all respects a paper on *renal surgery* generally; and looking at the various details and suggestions, such as the directions for operation, etc., and comparing the same with the present-day procedure, it might fairly be described as *up-to-date*, excepting, of course, in the matter of antisepsis, etc. We did not know much in that direction in those days, and, therefore, for obvious reasons it was not mentioned.

There was an amusing circumstance in connection with my paper which I do not like to omit. As was the custom then, so, I suppose, is the case still. It was the duty of the author of the previous paper to open the debate on the paper at the following meeting. On the Saturday morning of October 9th, 1869, the gentleman in question came to me to know what I would advise him to do, as neither he nor anybody else knew anything about the subject. So I lent him my paper to have a look through with the view of helping him to some ideas for getting over the difficulty; but he looked me up again in the afternoon and said it was quite hopeless! Now, as I did not want to have a dull evening, I suggested to him that he should roundly abuse me—*and he did!* This onslaught on his part had the desired effect, for immediately he had finished, a very enthusiastic speaker, Dr. De Leifdé, got up and vigorously took up my defence and thereby started a very animated, if *not* a strictly *renal surgery*, debate, which in the end brought from the venerable chairman and honorary president, the late Mr. Edward Cock (dear old "Teddy"), some very appreciative remarks, with the confident assurance that, given a suitable case, he would not hesitate to undertake the operation! But, as we all know, it was left to Mr. Lucas, Sir Henry Morris, and others to see to it later on, and right well have they succeeded!

The original notes (from which the copy of the paper, word for word, was written) I have preserved, and at the conversazione last year each page was shown enclosed between two sheets of glass, and the whole forty-three slides contained in a neatly constructed box for exhibition at the conversazione last autumn. After the meeting the "specimens" were, by request, sent to the museum, but I expect they have, long ago, gone the way of all flesh!

Modesty prompts me to withhold the fact that at the end of that Winter Session the Vice-Presidents honoured the author by awarding the first prize to his paper, presumably on account of its originality. *Justice*, however, says otherwise; because what I might almost call the historical interests of the Guy's Hospital Pupils' Physical Society demands of me, and I dare to say it, that it was *there*, in 1869, was demonstrated *by experiment* (and that, too, by one who utterly detests *all unnecessary* cruelty to animals), that some of the early dawn of renal surgery became to a certain extent visible on the professional horizon. And I am proud to think that it was chiefly by Guy's men—specially including Sir Henry Morris, the greatest authority, in my opinion, at the present time on renal surgery, and who was H.-S. and a Vice-President of the Physical Society during the earlier part of my time—that the practical initiation of renal surgery was subsequently and so successfully advanced.

Lastly, I should like to avail myself of the present opportunity of adding a bit of advice to all whom it may concern, but more especially to all those new students who, fortunate in their selection of a medical school, are about to enter at Guy's Hospital, and it is this:—by all means habitually attend the meetings of the Physical and other Debating Societies and endeavour to take your part in discussions, never minding the mistakes you make or the pit-falls into which you now and then will stumble—most of us have done so before you, and enjoyed the fun of it, too! One of the greatest authorities on, and best teachers of, the practice of surgery (the late Mr. Thomas Bryant) used to tell us in his annual lecture on the *mistakes of the year* that some of the best and most lasting of knowledge was learnt by those very mistakes. Therefore, see to it that you join in the debates to which I have referred, for in after life every doctor is pretty sure to be called upon, and that, too, often unexpectedly, to address some private or public meeting, and it is impossible to over-estimate the great advantage in such circumstances of the cultivated gift of *impromptu* oratory. Some of the best speakers to whom it has been my pleasure to listen are distinguished men both on the medical and surgical side of the Consulting Staff of my *alma mater*.

I must not mention names, but I am sure they will all take it quite *Goodh(e)artedly* when I presume to think that they would readily admit it as a truth that some of their success in this matter of public speaking was traceable to the practice of debate at the Physical Society—and elsewhere—years ago. So, in his own interest would I urge the regular attendance there of every Guy's student.

Grove Park, Kent. F. G. LARKIN.

The Silly Season.

Sir,—In your issue of August 2nd there is a letter to the Take-in H.S. which reminds me of an incident which happened thirty-nine years ago, and may help to fill an issue during the above season.

A week had just elapsed since I had begun a year's medical studies at a country hospital, a method frequently adopted in those days, when I was rung up—no! I beg your pardon—called up at 1 a.m., to go to the hospital at once. On arrival, it was to find a case had just been brought in with a crushed leg, owing to a railway accident, and that amputation below the knee was necessary.

As the first student to reach the hospital, I was given the place of "honour," viz., to sit on a stool at the foot of the operating table and "hold the leg" that was to come off.

In due course the leg came off, and not until that moment had I realized that it would be in my hands severed from the body. For a second a slight shiver went through me, and I wondered what to do with it! However, quicker than it takes to write I had duly deposited it in the tray with sawdust which was between my feet to catch the dripping blood. That done, I helped to pick up the arteries, etc., and had duly seen my first operation without turning a hair, bar the "slight shiver."

The sequel is interesting. A few days afterwards I was "looking on," with no duties to perform, otherwise than using my optic nerves, at the removal of dead bone from a great toe, and the surgeon was using a gouge—I turned sick and faint, and had to leave the operating theatre.

The psychology of the two episodes is interesting.

Thirty-nine years ago! and every detail is firmly impressed on my mind, whilst patients are a thing of the past, and golf, sailing, gardening, and reading, occupy my happy leisure hours.—Yours faithfully,

A YOUNG FOSSIL.

Papers by Guy's Men.

M. S. Pembrey, M.A., M.D. Oxon.: Heat-stroke.—*Journal of R.A.M.C.*, August, 1913.

F. J. Steward, M.S., F.R.C.S.: An Address on Gall-Stones.—*Clinical Journal*, August 20th. 1913.

W. Sheen, M.S., F.R.C.S.: Diagnosis in Abdominal Emergencies.—*Clinical Journal*, August 6th, 1913.

Papers Received.—Middlesex Hospital Journal, St. George's Hospital Gazette, St. Bartholomew's Hospital Journal, The Polyclinic, The Nursing Times, The Hospital, The Clinical Journal, New York State Journal of Medicine.

Appointments.

Naval and Military.

Lieut.-Colonel S. E. Prall, M.B., B.S. Lond., I.M.S., to act as Health Officer of the Port of Bombay, pending further orders.

Captain H. C. Keates, I.M.S., has handed over the duties of Superintendent of the Campbellpur District Jail from 31st May, 1913.

Captain J. H. Horton, D.S.O., I.M.S., joins the Bombay Civil Medical Department.

Captain R. P. Lewis, R.A.M.C., has been appointed for duty to the Aldershot Command.

Captain H. O. M. Beadnell, R.A.M.C., has been appointed for duty to the Southern Command.

Captain M. C. Wetherell, R.A.M.C., has been appointed for duty to the Irish Command.

Captain J. E. Powell, R.A.M.C., has been selected for appointment as Specialist in Dermatology at Hilsea.

Captain R. P. Lewis, R.A.M.C., has been selected for appointment as Specialist in Physicial Training at Aldershot.

Civil.

H. Rowse Bastard, M.R.C.S., L.R.C.P.; R.S.O. at Schiff Home, Cobham, Surrey.

Results of Examinations.

Passed for promotion to rank of Major—In Appendix xi., K.R., subject (*b*)—Captain S. C. Bowle, R.A.M.C.

Clinical Assistants in Special Departments.

Applications are invited for the following vacancies and should be sent in to the Treasurer, Superintendent's Office, on or before Saturday, September 13th:—

Ophthalmic, three ordinary Clinical Assistants; Throat and Ear, three ordinary; Neurological, two ordinary; Children, two ordinary; Genito-Urinary, one ordinary and one chief; Vaccine, one ordinary; Orthopædic, one chief and two ordinary; Actino-therapeutic, one chief and two ordinary; Skiagraphic (Medical), one chief and two ordinary; Skiagraphic (Surgical), one chief and two ordinary.

Births.

ELLIS.—On August 15th, at 14, Clavering Avenue, Barnes, S.W., the wife of Tom Bertie Royal Ellis, L.D.S., of a son (John Bernard Royal).

HAMMOND-SMITH.—On August 19th, at 29, Hart Street, Henley-on-Thames, to Mr. and Mrs Hammond-Smith, a daughter.

LUCAS.—On July 30th, at Edmonton, Alberta, the wife of Christopher Lucas (née Archbold) of a daughter.

POOCK.—On Tuesday, August 12th, 1913, at "Clareville," Dorchester, Dorset, the wife of Graham Poock, B.A. Cantab., L.D.S. Eng., of a son.

Correction.—In the announcement in our last issue, under "Death," the name "Endsall" should have read "Edsall." We apologise for the error.

G. T. M.

GUY'S HOSPITAL GAZETTE.

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Passim.

AS we announced in a preliminary note in our last number, the custom of celebrating the opening of a new school year by a dinner in the Students' Club, is to be renewed this year, and it is confidently hoped that the function will rise from its ashes, revivified like the Phœnix, and eclipse in its success the many enjoyable dinners of the past. We hear with the greatest pleasure that our President, Mr. Cosmo Bonsor, will preside, also we understand that in the course of the evening the names of the Prize Winners during the past year will be announced. The successful men will be the guests of the School.

IF the dinner is to be a real success we should like to see a truly representative gathering of Guy's men in the College Dining-room on October 1st. We hope to see many old Guy's men in addition to men still up here. There are many old Guy's men in London and its immediate neighbourhood who would find a keen enjoyment in meeting their contemporaries once more under Astley Cooper's portrait, and in encouraging their younger brothers to persevere towards the goal they have themselves reached.

IN addition to a big contingent of Past men we also sincerely hope to see a large number of First and Second Year men. These men are too apt to think that these functions are largely intended for their seniors in the wards. Never was there a greater mistake; the great object in view is always to promote really representative gatherings of Guy's men, including both those in the wards and those who are still struggling with the preliminary sciences. It is only by attending these and similar gatherings that a man can ever fully appreciate and understand the inner life of the hospital, and without that knowledge no man truly imbibes the real Guy's spirit. When we talk of junior men we include also, of course, those Freshmen who have just entered our walls and who should on no account miss this opportunity to participate in the life of their new Alma Mater, and see at once what manner of men their new colleagues and friends may be.

THE Dinner will be held on October 1st, at 7.30 p.m. in the Students' Club, and tickets, price 3s. 6d. each, may be obtained at the Medical School Office.

IN the days before we were foolhardy enough to take charge of the GAZETTE we were wont to criticize severely the Editor who filled a column of Passim during the summer months with a lament over the absence of material to fill his pages. It was so easy to say "why didn't he put by something from the months of plenty in anticipation of the lean season." Alas, we have repented our harsh thoughts in sackcloth and ashes during the last few weeks, and humbly retracted anything we have said. At present there is a veritable famine, not so much

in contributions but in our own ideas. We feel much sympathy with the grasshopper in the fable who played about during the warm weather, and made no store, so that he perished of hunger when the frost came. However, we take some comfort in the thought that the famine season is almost over and that the opening of the new session will see us in a land of plenty once more.

WHEN our friends and critics are in a genial mood, and refrain from telling us in candid language how utterly bad and uninteresting the last number of the GAZETTE is, with especial reference to the worthlessness of "Passim," it is customary for them to dilate upon the absence of any articles or verses in a humorous vein. Our retort to this gibe is, of course, easy and effective, but, unfortunately, it has no result, neither the critics nor the uncomplaining public ever make the effort to contribute anything in the nature of light sketches or verses. This dearth, of which successive Passimists have complained from time to time over many years, is somewhat of a mystery. It surely cannot be for lack of material, nor yet for lack of those capable of writing these articles. There must be quite a number of men or nurses who could send us some very amusing work if they would only make the attempt. We have especially chosen this season of the year to make this appeal for contributions to a "Lighter Vein" column, because most of us are returned fit and full of energy from our holidays (however brief), and this is the true time to make fresh resolutions and to break new ground rather than the New Year, when we have already settled down into all the old bad habits again.

From the point of view of the student and recently qualified man it is, perhaps, a pity that the nurses are expected to see that patients remove their false teeth before coming into the theatre for operation. It is far more difficult for the clerk to remember the importance of always looking into the patient's mouth to see that it is clear, when he knows that in the hospital it is only a matter of form, and that he will almost certainly find no tooth plate. What is only a mere routine in hospital is, of course, of the greatest practical importance in private work, and one feels sure that the fact, that fatal accidents only rarely occur, is, in many cases, due rather to good luck than to good management.

The Residents and Junior Staff Anæsthetists are almost always guilty of the sin of omission in not looking into the patient's mouth, and they sin chiefly, no doubt, because they know they will find nothing, but, partly also, because many of them remember well the indignant looks darted at them by the sister or nurse in charge of the case, if they dared to examine the patient's mouth when they first gave anæsthetics on their own responsibility. The feeling which prevails, or did prevail, among the nurses, that the anæsthetist casts a reflection on them, in satisfying himself that the patient's mouth is clear, is easily understandable, but a little reflection soon shows how unreasonable it is.

If by any chance a plate were left in and a fatal accident occurred, the chief legal and moral responsibility would fall, not on the careless nurse, but on the equally careless anæsthetist. It is obviously not fair to expect the anæsthetist to trust entirely anyone else in a matter entailing so heavy a responsibility upon himself.

A CORRESPONDENT has written to us recently on the subject of the M.C. Degree of Cambridge. His attention was directed to the subject by the result of the recent examination, when out of nine candidates the two Guy's men were alone successful. It appears that during the last eight years the degree has been given twenty-four times, and exactly half of that number have been granted to Guy's men. These facts are eloquent testimony to the general excellence of the surgical training of the hospital, and also suggest that a very large proportion of the best Cambridge men who come to London make Guy's their new home.

WE have recently heard that David Hoare, who worked as Assistant in the Museum for 42 years, died towards the latter end of June. Hoare, who will be well remembered by many

generations of Guy's men, retired ten or twelve years ago on a pension, he having become incapacitated from further work as the result of a cellulitis of one hand. He was 78 years old at the time of his death.

The following letter from a patient is an interesting testimonial to the value of Compulsory Education :—

Doctor Sir

My ears are still very bad with ringing humming noises in both my ears and I am suffering with deep bulging upwind and heavy sickness again.

And I am afraid to eat any heavy food fearing of fetching it all up again and it rising in my hinside Like a lot of hot oil and have a sickly taste in my mouth Sir I hope you will kindly do what you can to stop my sickness and reaching.

Yours gratis,

Mr. ———

Aug. 14th.

If the poor man's condition is at all like his description, we have no doubt he would willingly give himself away *gratis*, he cannot be very valuable even to himself. He is evidently one of those cases of what for want of a more appropriate or less controversial term is called alimentary toxæmia, and doubtless one could forecast the treatment he would receive, with considerable accuracy, accordingly as he fell into the hands of one or other of the great protagonists in that condition.

The Works Department has almost finished the reconstruction of the Old Operating Theatre which has been going on for some time now, and in its place is a smaller, more compact theatre to be used for demonstrations. The benches are still arranged in tiers one above the other, but the skylight which used to be so prominent from the Front Quadrangle has been taken away completely. Another change which has occurred is the conversion of the big landing just outside Luke into an operating room, and of what was Cole's instrument room into a preparation room, so that there will be in future eight operating theatres, two on the first floor, three on the second, and three on the third. When one sees the length of the operation list on Tuesdays and Fridays and the number of surgeons who all wish to operate about the same time, it is obvious that eight theatres are not at all too many.

That valuable journal, *Surgery, Gynæcology and Obstetrics*, has recently adopted a new feature which should be greatly appreciated. This is no less than an abstract of all that is best in the current surgical literature of Europe and America, with a complete index of all published articles. The editors are assisted by a consulting staff made up of representatives in all the leading centres of surgical activity, and the number of eminent names appearing in this list is a guarantee of the excellence of the work. Anyone who wishes to keep abreast of the myriad papers in any branch of surgery will find this abstract of the greatest assistance.

A Case of Recurrent Intussusception.

By EDWARD M. MAHON.

Thomas James ——, aged 3, was admitted into Clinical on July 15th, 1913, for abdominal pain, vomiting, and passage of blood per rectum.

In November, 1910, the patient, then aged 3½ months, was admitted into Clinical for a similar attack of abdominal pain, vomiting, and passage of blood per rectum. An intussusception was diagnosed, and Mr. Fagge operated, and found the ileum intussuscepted into the ileum, and thence through the ileo-cæcal valve into the colon. On reduction the gut was found to be very black, and it was questionable whether it was recoverable. This intussusception is said to have been of eleven hours' standing.

The history of the present condition was that the patient had been perfectly well since his first intussusception until the day of his present admission. At 9.30 a.m. the patient had a sudden paroxysm of abdominal pain, which lasted about four minutes, and caused him to fall to the floor. Vomiting accompanied the pain. After this attack the patient felt quite well again, but during the next eight hours there were about twenty-four similar attacks. At 2.15 p.m. tenesmus accompanied a paroxysm of pain, and, on stooling, blood was passed. With every subsequent paroxysm there was tenesmus and passage of blood.

The patient was seen in the Surgery eight hours after the first attack of pain. The abdomen was then quite soft and moved well on respiration, but there was some tenderness beneath the costal cartilages of the right side. At first nothing could be felt in the abdomen, but

during palpation a sausage shaped lump appeared below the costal margin of the right side and then disappeared. On rectal examination nothing abnormal was felt, but on withdrawing the examining finger it was found to be covered with blood. A diagnosis of Intussusception was made and the patient admitted into Clinical.

Mr. Hughes operated 11¾ hours after the first onset of symptoms. On examination under anæsthesia a distinct mass could be felt below the costal cartilages of the right side. The abdomen was opened through a rectus incision, and then the cæcum was found to be missing from the right iliac fossa, but a mass was discovered high up in the right hypochondrium. This mass proved to be large intestine with the ileum passing into it, and appeared to contain ileum, cæcum, appendix, and the ascending colon. Reduction was easy, the colon first appearing, then the appendix, cæcum, and ileum; the last part of the reduction was ileum from ileum. The intussusception began two inches from the end of the ileum, and no obvious condition was found which could account for its origin.

The patient made a rapid and uneventful recovery.

The recurrence of an intussusception in children after reduction by an abdominal section is a very rare condition, and at present I have only been able to find the records of six cases.

Mr. Charles P. B. Clubbe in his "Diagnosis and Treatment of Intussusception," on page 54 writes:—"A recurrence, following a supposed complete reduction by injection or inflation, does occur and must always be expected. But a recurrent invagination coming immediately, or soon after reduction has been effected by laparotomy is very rare. It did not occur in any of my cases. In my series I find I have operated on two children for recurrent intussusception coming on two and six months after the first operation." Mr. Clubbe's series consisted of 144 cases, and extended over a period of thirteen years.

Messrs. Adams and Cassidy in their "Acute Abdominal Diseases" (page 173) only record one recurrence in 100 cases, and this occurred five weeks after the operation.

Mr. D'Arcy Power in his book "Some Points in the Anatomy, Pathology, and Surgery of Intussusception," writes on page 70;—"An intussusception sometimes recurs after it has been reduced by abdominal section, but recurrence is less usual after an abdominal section has been done than when reduction has been brought about by irrigation. In a few cases the intestine has remained so œdematous that the tumour has been felt after the wound has been closed, leading the operator to suppose that invagination has recurred. Such a condition may be distinguished from true recurrence by the fact that the swelling rapidly disappears, and with it the symptoms of obstruction. This is a rare accident, but Mr. Pearce Gould[1] met with a rarer one in which he performed a laparotomy twice at an interval of three months for the reduction of two separate intussusceptions in the same patient."

1 *British Medical Journal*, 1895, vol. ii., page 1356.

Two papers dealing with this condition are catalogued in the "Index-Catalogue of the Library of the Surgeon General's Office, United States Army," vol. viii., 1903. One of these papers is by Mr. C. N. Dowd, and appeared in *Medicine*, Detroit, 1901, vol. iii., pages 295-299, and reports a recurrence three and a half months after the first operation. The other paper is by Mr. Cleveland and deals with a recurrence at five weeks.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—ED., G.H.G.]

Anent the Resurrectionist.

SIR,—When I was a Student at Guy's in 1872, I was very friendly with Willie Hinton, the son of James Hinton, Aural Surgeon to Guy's, and used frequently to go to his house in Saville Row. One day Mr. Hinton recited the following epitaph to us, and acknowledged that he didn't know where it came from, nor who wrote it.

"Here lies an honest man, my brothers,
Who raised himself by raising others;
Anxious his soul from soil to save,
His converse still was with the grave;
To rescue from the tomb his mission.
He took oft to the Physician,
And strove that all whom death releases,
Should rest—not in peace, in pieces,
Here he waits *his* resurrection,
In hopes *his* life will bear dissection."

R. B.

31, Girdler's Road,
West Kensington.

Renal Surgery.

SIR,—I am delighted beyond words to find I have made one more "mistake" in my reference in my letter (*re* Renal Surgery) as regards our dear old friend, Mr. Thomas Bryant, who I am, like many other old Guy's men, glad to learn is still spared to us. I had already expressed my satisfaction in the "copy" for the printers when, at the last moment, in going to press I happened to learn from *two* other younger Guy's men that our venerable old teacher had passed away months ago! So, unfortunately, I hastened to make the "correction." Ah, well, I am glad to find I made *that* "mistake" anyhow!—Yours truly,

Craven House, Grove Park, Kent, S.E.
September 8th, 1913.

F. G. LARKIN.

Strangulated Hernia.

CLINICAL LECTURE BY MR. E. C. HUGHES.

A HERNIA is strangulated, when its contents are irreducible, when their blood supply is increasingly interfered with, and when, in the event of the contents being bowel, there is an obstacle to the passage of intestinal contents through it. If the hernia is only omental, the first two conditions constitute strangulation.

In the case of inguinal hernia the cause of the strangulation may be in the sac itself or in the tissues surrounding it. You will frequently notice, during an operation for a radical cure, that the sac has a distinct circular thickening projecting into its interior and diminishing its calibre at that point. This point is either at the internal abdominal ring or a little way down the inguinal canal. If a piece of bowel is suddenly forced past this narrow part, it may be impossible to return it to the abdomen owing to the bowel being gripped. It is in this way that many herniæ of recent appearance are strangulated.

It is surprising how comparatively frail the thickening may be. I was recently operating on a case of reduction *en masse*, which, as you know, is the apparent reduction of a hernia, but without relief to the interference with the blood supply of the bowel. Here the sac was so thin it was almost transparent, and the thickened band was only a very inconsiderable elevation into its interior, but still it was sufficient to have caused the strangulation.

Herniæ of old standing, and particularly when a truss has been worn, develop very thick sacs, and the site of strangulation is at or near the external abdominal ring. Sometimes it is this ring which is the obstructing agent, for after dividing the ring it is very easy to reduce the hernia. At other times, and usually, it is the condensation of tissues in and about the sac which acts as the strangulating agent. In femoral hernia the constricting agent is Gimbernat's ligament.

Let us see what happens to the bowel and sac when strangulation occurs. The blood supply becomes increasingly embarrassed; at first the venous return alone is interfered with, and then the arterial supply. The loop of bowel becomes congested, being overloaded with venous blood, and an exudation of fluid takes place into the sac. At first the fluid is clear, but soon becomes blood-stained, and, if the strangulation is not relieved, fæculent in odour, and finally contains the intestinal contents of the bowel.

During the stage of congestion of the bowel, its colour varies, passing from a deep red to black. The blackness is due to the extremely slow escape of venous blood. As the arterial supply gets cut off, the bowel becomes grey in colour, flabby in appearance and flabby to the touch. Black bowel does not mean gangrene: it seldom means more than extreme congestion; and this black bowel is firm and resilient to the touch. I think the feel of the bowel is more important than the colour in deciding whether gangrene has occurred. The bowel may be damaged in various ways; the most usual result is to find that the bowel has suffered most where the constricting agent has gripped it, for when the bowel is pulled down to inspect this region you will see the indentation of the strangling agent, and if the process has been at work long enough there will be patches of dead tissue with perhaps openings leading into the bowel; another result is to find gangrenous areas in the loop of the bowel away from the neck of the sac, or the whole loop will be gangrenous.

In femoral herniæ, it is not at all uncommon to meet with a Richter's hernia, which is one where only a portion of the circumference has been strangled; it is important to remember this type, because although strangled it is possible for intestinal contents to pass along. Thus a wrong diagnosis may be made because it appears not to be a case of intestinal obstruction. Another type of hernia which may lead to a similar mistake is that known as Littré's, where Meckel's diverticulum is strangled, but there may be no signs of intestinal obstruction.

The diagnosis of a strangulated hernia is, as a rule, very easy; the symptoms are those of an acute intestinal obstruction with the local ones due to the presence of the hernia. Let us take the local signs first; a hard painful lump has suddenly appeared in one of the hernial regions, and there may or may not be a history of a hernia having been present before, or if there had previously been an irreducible hernia, it has become larger, harder, and painful. The hardness and increase in size is due to the sac becoming rapidly distended with fluid. The hernia is irreducible, and there is no impulse on coughing, which means that raising the intra-abdominal pressure does not force back any extra blood into the affected loop of bowel, nor any intestinal contents into the loop.

The general signs are sudden pain, which may be referred vaguely to the umbilicus, but usually to the hernia, sickness, and a variable amount of shock. There is then a pause, but in a short time, a very short time if the patient continues to take food, the vomiting begins again, at first gastric in nature, and, then, biliary, and, finally stercoraceous. No fæces nor flatus are passed, unless the bowel below the obstruction contains some material, when that may be got rid of, but afterwards, in spite of enemata and drugs, nothing more will be passed. The abdomen becomes progressively distended, and in a short time the patient dies.

These are the general signs of strangulation of the bowel, but if omentum only is effected, there may be no general signs other than the initial pain, vomiting and shock.

Although the diagnosis is easy, mistakes are occasionally made, and the commonest mistake is to neglect to examine the hernial orifices in a case of intestinal obstruction. It has not uncommonly happened that a small strangulated femoral hernia has been overlooked, and the abdomen unnecessarily opened to look for the cause of the obstruction.

I made this mistake three or four years ago. A woman was admitted with intestinal obstruction and had an irreducible femoral hernia. This hernia, however, was not tense, and that is very unusual unless gangrene has occurred, but in this case the history of the illness was very recent. On account of this recent history and the slackness of the sac, I opened the abdomen to find that after all it was a strangulated femoral hernia.

Sometimes the mistake is made in the opposite direction; a hernia is operated on on the supposition that it is strangled and is the cause of the intestinal obstruction, and operation shows that the coil of bowel, though distended, is not obstructed. A case of this kind I remember seeing as a ward clerk—a man with an enormously distended abdomen had a large, tense, irreducible hernia. Operation showed distended but not strangled bowel in the sac, and on further exploring a growth of the sigmoid. In this case the intestine behind the obstruction had become distended, and on account of the increased intra-abdominal pressure and the presence of a hernial sac, a loop had been forced into the sac. However, it is a good rule to explore an irreducible hernia when there are signs of intestinal obstruction, although the local signs may not suggest the hernia is strangled.

We need not enter further into the diagnosis than to recall that there are other conditions which simulate strangulation, *e.g.*, torsion of a testicle, torsion of the omentum, etc., etc., all of which conditions demand immediate operation.

I want to draw your attention to what is known as an obstructed or incarcerated hernia; here the hernia is irreducible, and the intestinal contents cannot pass along, but there is no interference with the vascular supply of the bowel. This can only be when there is a hernia of the large intestine and the bowel is blocked with fæces, or elsewhere in the intestine when there is a foreign body travelling along it. You must not imagine that a hernia passes through this incarcerated stage before becoming strangled. I believe that this point of distinction is made between the two conditions, that in the former there is an impulse on coughing, while in the latter it is absent; but whether an impulse is present or not (it will very soon disappear) a recently irreducible hernia, or an old-standing hernia which has recently increased in size, which is painful and tense with or without the initial vomiting, is a strangulated hernia.

Taxis may be attempted if the strangulation is recent, but it must be done gently. As you do it, you must remember that the gut is gripped at the neck of the sac and force wrongly applied may tend to increase the damage to the bowel at this point. A femoral hernia is damaged earlier than an inguinal owing to the sharp tense edge of Gimbernat's ligament. Mr. Symonds used to teach that no attempt should be made to reduce a femoral hernia after six hours, an inguinal after twelve, and he made it a rule, and it is a good one, to feed patients at once after reduction by taxis. For it is possible to have reduced the hernia *en masse*, and starvation after this will delay the development of signs of intestinal obstruction, while immediate feeding will make it obvious in a very short time.

If taxis has failed prepare for operation, and while doing so you can elevate the foot of the bed, give an enema and put on an ice bag, but you must not waste time over these details. The sac in an inguinal hernia is very easily exposed and isolated from surrounding structures, while in a femoral it is not so obvious, as it is usually thickened by an adherent gland and a condensation of the surrounding fat, and you may have to cut through several layers before you get on to the actual sac.

Open the sac and note the nature and smell of the fluid that escapes, and the colour of the bowel, its appearance and texture.

1. The bowel will recover when replaced in the abdomen; here the fluid is clear or blood-stained and sweet smelling, the bowel is congested and may be black, but it is firm and resilient. The bowel at the site of constriction must be examined, for the damage here is likely to be most intense; divide the constricting band and draw down the intestine so as to bring the constricted part into view. Examine it carefully, see that there are no local patches of necrosis, no openings into the bowel, but that there is no more than a constriction due to the band.

The division of the constricting band is very easily done in an inguinal hernia from without inwards; you must not use the old-fashioned hernia knife and director, for with them the section of the band is made from within outwards, and the tissues are not divided in full view of the eye, and if the intestine is at all distended, it tends most obstinately to endeavour to meet the edge of the knife. In a femoral hernia, it is safest to divide Gimbernat's ligament outside the sac; the ligament is exposed and its outer edge nicked. After deciding that the bowel is alive, return it to the abdomen and complete the operation by doing a radical cure.

2. The bowel is gangrenous in part or in whole; here the fluid is fæculent in odour.

(*a*) the gangrenous areas are small; there may be a small gap where the bowel was gripped at the neck of the sac, while the remainder is not seriously damaged. In this case the part may be buried by means of a purse-string suture, but after doing this you must be careful to see that you have not diminished the lumen of the bowel to too great an extent. Return the bowel to the abdomen and complete your operation, leaving a tube down to the region of the neck of the sac.

(*b*) The gangrenous area involves the whole or greater part of the gut.

Your procedure depends on the condition of the patient; if it is necessary to finish the operation as quickly as possible, you need do no more than cut away the convexity of the loop, put a tube into the bowel and allow the contents to escape; that is to say you make an artificial anus. This will relieve the intestinal obstruction, and as soon as the condition of the patient allows of it, you must proceed to close the artificial anus.

This temporary anus acts very well indeed, except in small femoral herniæ, where the escape of intestinal contents may not be free enough to entirely allow the symptoms of intestinal obstruction to subside. But still it does improve the patient's condition, and in 24-48 hours she may be strong enough to allow of a further operation, a lateral anastomosis through a second incision.

Let us now consider a case where the patient's condition is *not* desperate, and where the bowel is gangrenous. Make a separate opening into the abdomen and make a lateral anastomosis between the bowel above and below the affected part and about twelve inches away from it. Leave the gangrenous part in the hernial region, if it be firmly adherent, with a tube in it; but if not firmly adherent draw the gangrenous part out through the abdominal opening, being very careful to allow no intestinal contents to escape in doing so. This operation restores the intestinal continuity, but leaves a fæcal fistula, which can be closed at a subsequent operation. After doing an anastomosis the obstruction rapidly passes off, and the gangrenous part can be cut away forty-eight hours later and the ends closed. This secondary operation is very simple, and can be done without an anæsthetic. But if the operation is delayed some weeks the closure of the fæcal fistula is a more difficult operation, and may be formidable on account of adhesions.

I advise this treatment and not immediate resection and suture of the divided ends for the following reasons: the latter will take twice as long as a lateral anastomosis, the patient as a rule is not in good condition if the bowel has been strangled long enough to produce gangrene, and it is difficult to know how much to resect. Considerably more than the dead area will have to be removed, and it has not infrequently been found that gangrene has occurred at the bowel junction after resection.

3. The condition of the bowel is doubtful. There are a very few cases where there is uncertainty about the vitality of the bowel; in these cases the loop can be returned just inside the abdomen with a tube or drain near it. If the bowel gives way, the tube will guide the intestinal contents away, but if all goes well, and this will be obvious in twenty-four hours, a radical cure can then be performed.

But in these doubtful cases it is better to do a lateral anastomosis, excluding the damaged part, which will thereby be relieved of a certain amount of strain.

The Public and Venereal Disease.

THE resolutions passed at the International Congress of Medicine recently, and the subsequent announcement that the Government were going to appoint a Royal Commission to investigate the subject of venereal disease, have aroused public interest in this question in a more than transitory manner.

It is true that the articles in the daily papers did not continue for more than a week, and one of the most popular of them referred so often to syphilis as "the hidden plague," that unfortunate people suffering from tuberculosis were led to believe that salvarsan would cure them; but courageous and outspoken articles are already appearing in the reviews, and there is little doubt that once the Commission is formed the curiosity of the public will prevent suppression of evidence, and it is scarcely possible that anything but good can follow such an increase in popular knowledge.

In the *English Review* of this month there appears an article, entitled, "The Doctors and Venereal Disease," which deals with the facts of syphilitic infection and its treatment, more boldly and clearly, perhaps, than has any previous article appearing in a periodical with a wide general circulation. Very great stress is laid by the writer on the curability of syphilis, and in this, perhaps, he is wise, for there is probably no other single factor that so largely keeps thousands of syphilitics away from treatment as the common belief that the disease is intractable. And it is again the fact that treatment is so successful that makes it worth while to single out syphilis as a disease that it will repay the State to investigate and attempt to exterminate.

It is very remarkable how widespread is the belief in the incurability of syphilis, even among members of our own profession. The present writer heard a doctor declare, not long ago, that he would not be infected with syphilis even if by so doing he could earn £10,000; the writer in the *English Review* quotes a prominent English medical man, who at an International Conference at Berlin remarked "the man who gets syphilis had better shoot himself," to the astonishment of his continental colleagues. Now without in any way minimizing the serious nature of the disease, it must surely be beyond dispute that syphilis is in the majority of cases an entirely curable disease. It has always seemed to me that the establishment of a central department at Guy's for the treatment of syphilitics would be of enormous benefit not only for the patients, who would more easily learn the importance of thorough treatment, but also for the students who would thereby learn the real routine of treatment.

The majority of men leave hospital with an inadequate knowledge of mercurial and iodide treatment; the excitement created by the introduction of salvarsan has led to that drug being widely known, and the dosage is so simple that its essentials are known to everyone; but few men gain any knowledge of the routine of intramuscular injections or pill treatment, inunction is scarcely ever seen, and there is a general vaguely hopeful idea which is centred round Mist. Hydrarg. et Pot. Iod. (dose ʒi t.d.s.). It must, however, be remembered that the treatment of syphilis is not inexpensive, the drugs themselves are so costly as to be beyond the means of many patients, and it would be absurd to expect any doctor, working under a contract system, to provide his patients with salvarsan; even potassium iodide costs ten shillings a pound at hospital contract prices, and this will prove to be a very high price in the case of a patient consuming over a hundred grains daily.

But apart from all questions of treatment remains the subject of prophylaxis, and it is here that one foresees the storms of controversy, and the prospect is least hopeful. It is true that the Atlantic separates us from that country where men express their disapprobation with ladies' bathing dresses by tearing them off and trampling their wearers under foot; but we have ourselves a national hypocrisy and sentimentality that will terribly impede progress. For the prophylaxis of syphilis is intimately associated with the question of prostitution, and this is a subject which the Englishman is far too modest to discuss openly; it is true that one not infrequently hears a man praising continental license systems, but it is very seldom that one meets anyone with sufficient knowledge to discuss the extraordinary failure of those systems. And the whole thing is only furtively discussed.

I am told that venereal disease and prostitution are two of the leading motives in the great "Woman question"; if so, it may well be that discussion will be almost unlimited, but it is to be feared that Feminism will not lead to the most useful results. At a hospital "not a great distance from St. Thomas's Street," it was the custom of one of the Sisters to put cloth covers on the door-handles of the Men's Genito-Urinary Department, it never occurred to the good woman that a similar adornment of the Gynæcological Department would be equally useful (or rather useless).

And one is rather frightened by the ever-recurring articles containing descriptions of syphilitics—always men, five wicked men, with perhaps one innocent young mother; it strikes one as an exaggeration at a time when cold truth is greatly needed.

I suppose it will all end in further attempts to make the human race asexual, with, perhaps, another crop of rare and refreshing fruit from the lawyers. But in any case there is going to be a dreadful deal of talking.

T. I. B.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette." Guy's Hospital, London, S.E.*

The Resurrectionists.

III.

"'Tis hard one cannot lie amid
The mould, beneath a coffin-lid,
But thus the Faculty will bid
Their rogues break thro' it!
If they don't want us there, why did
They send us to it?"

Jack Hall, HOOD.

AFTER the surgeons and the schools the public is to be considered, although it is difficult to gauge with any precision the state of lay feeling on the matter. The lower classes (who, in the earlier years of the traffic, at any rate, were the chief sufferers by the depredations of the body-snatchers) were, at that date and in marked contrast with the present times, almost wholly inarticulate. Even so great a hardship as this only found expression from time to time in rough handling of a body-snatcher, a student, or a surgeon; whilst on occasions of intense excitement a medical school would suffer by their indignation.

Bransby Cooper tells us that down to the year 1789, when there were relatively very few students in anatomy, and not more than three or four lecturers on the science in London, the resurrection men had not received a distinctive name, although the newspaper reference we have quoted regarding Thomas Topham, the Islington Strong Man, would suggest that the idea afterwards generally adopted had already been expressed at a much earlier date.

But it is evidently true that the traffic made little impression on the public mind until long afterwards. The English people were not over-squeamish in the eighteenth century, and the populace that made common holiday to see men hanged was unlikely to be much distressed by the ultimate fate of a dead body other than that of a near relation; and public spectacles of this nature were freely provided by the law of the land. Before 1820 the executions in London numbered at least a hundred in each year, and in the chief part of the reign of George III. were especially numerous. And yet these hangings were to a great extent responsible for the repugnance that dissection generally inspired, dissection being part of the price the condemned murderer paid in expiation of his crime, an additional ignominy beyond that of the simple death penalty. Only in the nineteenth century when the increase of the population of the medical schools accentuated the disproportion between students and hangings did exhumation become the principal source of supply to the dissecting room. The increased demand and the greatly enhanced prices enlisted men of the most degraded character who quickly brought the traffic into that notoriety which the older and comparatively decent class of workers had managed to avoid; and the public, now fully awakened, was prepared to show little mercy to these ruffians when they were taken.

The attitude assumed by the law towards the trade was but little understood. Reputable surgeons appear to have been unaware of any illegality in profiting by an infringement of the laws on the part of the body-snatcher, although, as receivers, they were actually liable to be tried for misdemeanour and sentenced to severe penalties. It is true that magistrates generally refused to take cognisance of such cases unless there was clear evidence that the receiver had also taken part in the disinterment; yet both teachers and students had been convicted and actually punished for receiving bodies knowing them to have been unlawfully procured, and, as the law stood, it was at least doubtful whether every teacher and student was not indictable for a misdemeanour. There was another difficulty in regard to exhuming. No legal property in a dead body was then recognised, and unless some portion of the grave-clothes or of the coffin was removed at the same time, no prosecution for felony could be sustained.

One judge at length decided, in 1788, that this method of procuring bodies was a misdemeanour. But even then prosecutions were not common, and offenders when taken were usually liberated, for magistrates were loath to take action as long as no open scandal arose for fear of exciting popular prejudices.

Nevertheless, many obstacles were placed in the way of dissecting. The enormous increase in the number of students in London, which in 1823 totalled 1,000, and rose to an even greater height in 1825, when Guy's declared its independence, and in 1826, in two years fell to 800, of whom not more than 500 dissected. Many went to study anatomy in Paris, where in 1828 there were said to be as many as 200 English pupils. The Government had to face a considerable amount of unpopularity on this account, but, although confronted with the prospect of relegating the science of medicine in England to a position behind that of other European countries, delayed taking action until moved by public opinion to appoint the Royal Commission, and after a further delay of four years to pass the Anatomy Act of 1832.

On occasions when public feeling ran high there was scarcely any limit to what the mob would do. In Dublin at one specially scandalous time one of the anatomical schools was besieged for nearly a week in spite of the protection of the police, and most of the schools were unable to finish their winter courses of dissection at the proper time. The resurrectionists were frequently assaulted, and one of them died as a result of being flogged with a cat-o'-nine-tails made of wire, whilst another succumbed after a severe beating inflicted by the crowd, and many of them were thrown into the water. Medical men and stu-

dents were attacked, and the resurrectionists eventually transferred their operations to graveyards at a distance from the city, providing themselves with firearms, and they were often accompanied by students similarly armed.

When things were at their worst a notice was put up outside Guy's announcing that no one who died within the hospital would be subjected to examination after death. This was only a temporary measure to allay public feeling, for the patients and their friends had learnt to welcome a post-mortem examination as a guarantee of burial at the hospital's expense and of the special protection generally associated with interment in the official graveyard.

Bransby Cooper relates that the governors of a large hospital in London (which we may guess to have been situated "not a hundred miles away from" St. Thomas's Street) were anxious that their own burial ground should be preserved strictly inviolate, and to that end engaged a well-known and confidential resurrectionist at a handsome salary to take up his nightly station in a watch box on the premises during the dissecting season, and for some months the watchman proved himself vigilant and incorruptible. At the end of that time, however, one of the hospital surgeons engaged the members of another gang to procure him a body of special pathological interest that had been buried in that ground. These men having attempted by all the usual means to obtain the body, without success, eventually seduced the watchman to join them in an exhumation elsewhere, and whilst he was thus engaged so plied him with drink that the same night, although he had returned to his post, they were able to secure their prize without his knowledge.

Obtaining a subject from the dead-house, we are told, was a matter of great rarity, except at one hospital, which supplied its own school until the chaplain said he would no longer read the service over coffins full of stones.

For a long time citizens in more comfortable circumstances ignored or were ignorant of these exhumations. Whenever an isolated instance of the sort was brought to their notice there would be a little uplifting of the hands and eyes before turning to less unpleasant subjects, and the whole business was regarded as very distressing, no doubt, but obviously not their concern. Later, however, when the human jackals became bolder in seeking their prey and invaded graveyards other than those reserved for poorer folk, apathy gave way to panic. There was little comfort to be obtained from the declarations which Sir Astley Cooper, perhaps the highest authority on the subject, made before the Royal Commission, that "there is no person, *let his situation in life be what it may*, whom, if I were disposed to dissect, I could not obtain," and that "the law only enhances the price and does not prevent the exhumation: nobody is secured by the law; it only adds to the price of the subject."

Many were the precautions taken to circumvent the exhumators. Obviously the line to pursue was to render the body either inaccessible, or, failing that, unprofitable to the resurrectionist. In order to frustrate the resurrectionists in their efforts to reach the body until it had become worthless to them, special strong-rooms were erected in churchyards in which the coffins were deposited for several days before burial. With the same object, strong iron cages, or "mortsafes," were built up about the newly-made graves. Yet another device was the iron coffin. William Hunt, Guy's second founder, dying in 1829, desired that his remains should be placed in either a stone or a "patent and self-closing and unopenable iron coffin," and, as a contemporary newspaper suggests, had taken the further precaution of "throwing himself upon the hospitality of the surgeons," relying upon the principle of "honour among thieves," by arranging for his burial within the chapel crypt.

An advertisement has been preserved in which Edward Lillie Bridgman, of 34, Fish Street Hill, and Goswell Street Road, proclaims the virtues of "Bridgman's patent wrought-iron coffins, the same price as a wooden one, and is a superior substitute for lead," and also "patent cast-iron tombs and tablets."

"*If they carry me off in the patent coffin,*
Their labour will be in vain,
Let the undertaker see it bought of the maker,
Who lives by St. Martin's Lane,"

sings Robert Southey in a ragged ballad entitled "The Surgeon's Warning." But since he is constrained to relate that subsequently,

"*They burst the patent coffin first,*
And they cut through the lead;
And they laugh'd aloud, when they saw the shroud,
Because they had got at the dead,"

the cautious poet has remarked in a special preface, "that nothing here asserted concerning the aforesaid coffins is true, except that the maker and patentee lives by St. Martin's Lane."

These coffins, however, never attained any general popularity. Had they done so, by their very imperishability they would quickly have filled up all the burial space available. Amongst other precautions against the body-snatchers, spring-guns were frequently set in graveyards; but a woman attired in deep mourning would make the tour of the ground, and, stooping from time to time, would detach the wires in anticipation of a nocturnal visit. Relations sometimes elected to keep watch over a recent grave, but, finding themselves unsuited to the task, in the end delegated their charge to a professional watchman. But as these watchmen were more often than not in league with the body-snatchers, this precaution availed but little. For their greater comfort little "watch-houses" were built overlooking the graveyard, and one of these may still be seen by St. Mary Magdalene's, at the foot of Bermondsey Street.

R. M. W.

(To be continued.)

Obituary.

RUSSELL RODGERS,
L.D.S. Eng.

WE deeply regret to have to chronicle the death of Mr. Russell Rodgers, which took place in John ward on September 8th last. He had been in poor health for some time, but nothing very serious appeared to be wrong until just a few days before his death. When he was admitted, on September 4th, with a diagnosis of Addison's disease, the seriousness of his condition was realised, of course, but no suspicion was entertained that his end was very near indeed. A day or two after admission, however, he suddenly collapsed, and, in spite of every effort, never rallied again, but sank rapidly.

Rodgers entered in 1904 with the intention of taking medicine, and passed the Pre. Sci. (Lond.). After a time in the dissecting room, however, he changed his plans and took the dental course instead, qualifying in 1911.

He was always quiet and retiring, without a very large circle of friends in the hospital, but those of us who knew him well fully appreciated his sterling character and his charming nature. His family and friends have our deepest sympathy and sincere condolences in their great loss.

Appointments.

Civil.

W. Norwood East, M.D., has been appointed Medical Officer of Manchester Prison.

G. Frank Hardy, M.R.C.S., L.R.C.P., Assistant Tuberculosis Officer, Fulham Dispensary for the Prevention of Consumption.

H. L. Hopkins, M.B., B.S. Lond., Assistant M.O.H. and Tuberculosis Officer, West Suffolk.

A. S. Morton Palmer, M.A., M.D., B.C., to be Assistant Surgeon to the Worthing Hospital.

Change of Address.

W. Norwood East, M.D., from 97, King's Avenue, Clapham Park, S.W., to 171, Cheetham Hill Road, Manchester.

L. Price Harris, from Guy's Hospital to 14, Welbeck Street, Cavendish Square, W.

H. L. Hopkins, M.B., B.S. Lond., from the City of London Hospital for Diseases of the Chest, to 27, Angel Hill, Bury St. Edmund's.

Bernard Isaacs, L.D.S. Eng., from London to Mansion House Chambers, Adderley Street, Cape Town, South Africa.

R. O. Williams, M.D. Lond., M.B., B.S., to "Brackley," Bourke Street, Goulburn, N.S.W., Australia.

Reviews, etc.

Books for review should be addressed to The Editor, Gazette Office, Guy's Hospital, S.E. Their price should in every case be stated.

Surgery of the Lung. By C. Garrè and H. Quincke. Second edition. Translated by David M. Barcroft, M.D. Messrs. John Bale, Sons & Danielsson, Ltd. Price 12s. 6d. net.

This volume has a considerable value as a standard book of reference upon a subject which is as yet in its infancy in any part of the world and has hardly been born even in this country. Naturally it is impossible to speak with any authority upon a branch of surgery so immature, and all the conclusions drawn are merely provisional. Nevertheless, the views of the authors, whose experience relatively has been very great, are entitled to considerable weight and cannot be lightly disregarded. The descriptions of the operative technique are, in most instances, clear, and the chapter upon the methods for maintaining the expansion of the lung is exceedingly good. We cannot congratulate the translator upon the way he has performed his task. The English in many places is deplorable, and the text is not free from misprints which might have been corrected in the proof.

Clinical Surgical Diagnosis. By F. de Quervain (Basle). Translated from the fourth edition by J. Snowman, M.D. Messrs. John Bale, Sons & Danielsson, Ltd. Pp. 779. Price 25s. net.

This book is somewhat unusual in that, as its name suggests, it is devoted to one aspect only of surgical diseases, namely, their diagnosis; ætiology, pathology, prognosis, and treatment are not considered at all. The result is, of course, as might be expected, rather trying. You have followed the author in his remarkably clear and accurate picture of the clinical aspect of a disease, and wish to follow him still further into the domains of pathology and treatment, when, lo and behold! he has passed on to some other condition. Accepting, however, the limitations of the volume, inherent in its scope, one has nothing but praise for it. The descriptions are clear, lucid, and essentially clinical; the symptoms are enumerated and described, not in a long meaningless list nor even in the order of their importance, but according to the impression they make upon the patient. This arrangement is especially valuable to the student, since it helps to impress upon his mind the fact that many symptoms, relatively unimportant in themselves, are common to numerous unrelated diseases, and often, in the patient's estimation, overshadow the really significant ones. Altogether the book is an exceedingly valuable one, although, since it is a large book devoted entirely to

one aspect of surgery, its public must always be a small one. One gathers from it that de Quervain must be a really brilliant clinical teacher with whom it would be a pleasure to go round.

We must congratulate the author on the selection of his illustrations, and the publishers on their reproduction; they are, without exception, the best we have seen in any text-book. Dr. Snowman has performed the difficult task of translation in a very able fashion. We forgot most of the time that the book was not written originally in English.

The School Nurse: her Duties and Responsibilities. By C. Louis Leipoldt, F.R.C.S. Eng. The Scientific Press, London. Pp. 192, Price 2s. 6d.

We feel quite certain that this useful little book from the interesting pen of Mr. Leipoldt will have a large circulation among members of the nursing profession. The author is one of those medical men who took up the work of medical inspection for children of the London Elementary Schools when provision was first made for it by law. He has assisted in establishing the present excellent system of medical inspection out of the chaos, which existed during the first few years of work, when there was much unjustifiable opposition to the presence of the doctor and the nurse in the schools. He is well qualified to write upon such a subject, and his remarks as to the duties of the school nurse, the routine of inspection, and the difficulties to be overcome, will be found invaluable for any nurse who is proposing to take up the work.

Much of the work which falls to the lot of school nurses lies in the homes of the children, and hospital training alone cannot provide the experience and knowledge which is necessary. Mr. Leipoldt rightly lays stress upon this fact, and recommends a post-graduate course for the newly certificated hospital nurse, to be obtained in the department of the hospital almoner and by actual visits made to homes in company with the health visitors who are now to be found in all the London Municipal Boroughs. He suggests also that a further course of training should be undertaken for the certificate of the Royal Sanitary Institute.

There are excellent chapters upon the hygiene of the school and the life of the normal school child, together with an essay upon dietary. From these subjects the author passes on to consider disease as it occurs among school children. There are articles devoted to the infectious fevers, heart and lung trouble, nervous disorders, mental deficiency, deformities, and defects of the special senses. There is also a chapter on skin diseases.

Mr. Leipoldt's descriptions are brief, but they have not suffered on that account, for his phraseology is easy to understand and shows that careful attention to detail which those who know his work and writings have learned to expect from one of such undoubted literary ability. Few people could write such a small book, full of important facts, bristling with "tips" and directions, and keep the text so accurate and free from error.

There has been one change in the Elementary School curriculum which has been permitted by the Education department of the London County Council during the past two years concerning which Mr. Leipoldt says little. We refer to the permission for invalid children to attend school for morning sessions only. This is a most excellent licence, and we sincerely hope that it will not be withdrawn. It opens the door to a host of cases for whom a whole day's attendance, even at a special (Physical Defective) School, is too much, and who require a long mid-day or afternoon rest as a regular daily event. Only a few of the Special Schools make any attempt to provide for this want, and in those which we have visited the rest has not been sufficiently long nor has the necessary quiet been enforced. Cases of cardiac dilatation, chronic chorea, the habit spasms, nervous children, and those who exhibit night terrors, some of the infrequent forms of psychical epilepsy, those who are anæmic, and "who grow so fast," are examples of children for whom such arrangements are most beneficial.

If we have one fault to find with Mr. Leipoldt it is that he hardly lays sufficient stress, in his opening chapters, upon the enormous value of the school-nurse to the community. We happen to be in a position to know of the enormous benefit which has come to the child-life of South London, of the great bettering of the social conditions in the homes, which has already followed the work of medical inspection; of the mothers and elder daughters "at work" who are ashamed of being dirty and untidy because the lassie at school has been taught to be clean. The great improvement in general health which has followed has been due almost entirely to the activities of the school nurse, to her kindly example among small people who look up to her as a special friend, "much nicer than teacher," and there is still greater improvement coming. More power to her!

Our congratulations to Mr. Leipoldt for his useful and clever book.

Births.

DAVIDSON.—At Shillong, Assam, on August 14th, to Mr. and Mrs. J. Davidson (*née* L. M. Tippetts) a daughter (stillborn).

PILBEAM.—On August 24th, at "Claremont," Dovercourt, the wife of Edward Laurence Pilbeam, L.D.S. Eng., of H.M. Training Establishment, Shotley, near Harwich, of a daughter.

G. T. M.

GUY'S HOSPITAL GAZETTE.

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To the Freshmen.

"He hath neede of many parts, divers considerations and severall circumstances to proportion his desseigne justly. He ought to know the sicke man's complexion, his temper, his humours, his inclinations, his actions, his thoughts, and his imaginations. . . . In sickenes, he ought to be acquainted with the causes, with the signes, with the affections and criticall daies. In drugges he should understand their weight, their vertue and their operation, the country, the figure, the age, the dispensation. In all these parts he must know how to proportion them one to another; thereby to beget a perfect Symmetrie or due proportion of each part. . . ."

MONTAIGNE ESSAYS.

LOOKING through the back numbers of our hospital paper, we find that it has been the custom for many years now to devote the last issue in September to the needs of you, our new colleagues, and, we hope, readers.

Our first duty is a pleasant and easy one. We offer you a very hearty welcome in the name of all Guy's men, both past and present. We welcome you in the full expectation and belief that you will all absorb, continue, and transmit the old tradition of good work and straight dealing which characterises our School all over the world. We would also congratulate you or your guardians on the wisdom which has sent you to be nursed and mothered in your new profession by the old Borough Hospital. For she is a kindly and lovable old lady who will spend much time and trouble in helping you over the various obstacles which lie between the medical student and his ambition.

And now, our formal welcome over, we must endeavour to show you in a more practical manner our appreciation of your arrival by giving you a little advice which may be helpful in your first few days among us. If you will turn to the second half of this journal you will find there much close print dealing with the various activities of the hospital. And if you look through this you will see that the major half of it is devoted to the details of your future work, a goodly proportion to the rival attractions of the different sporting clubs, and a small space to particulars of the activities of clubs whose objects are mainly intellectual. The relative space allotted under these three main headings is an accidental occurrence, but at the same time it represents very fairly the lines on which the life of the average Guy's man, indeed of the average English student's life, is ordered. Of course there is much individual variation, but roughly our time is spent in unequal proportions on work, and physical and mental exercise and entertainment.

No doubt many of you will be somewhat dismayed and despondent by the evening of October 1st, when you have wandered unknown and unknowing through the Colonnade and the Park (a

source, by the way, of much joy and pride to Guy's men), and have vainly sought to find your way from the Medical School to the College, but be of good cheer. Remember that from the moment you have entered your name upon the books of the School you have become one of the great fraternity of Guy's men; a brotherhood which has ramifications throughout the whole of the Empire, and one whose members are always ready to stretch out the hand of friendship to fellow Guy's men wherever they may meet.

Remember, also, that your fellow students do not look upon you as an intruder in their sacred groves, but, rather, take it for granted that, since you have had sufficient good fortune to have had Guy's chosen for your School, or the perspicacity to choose it yourself, you are therefore worthy to be taken to their bosoms at once.

This school of Guy's is a very pleasant place in which to spend a few years, as you will find as soon as you have become acclimatised, and we predict that there is not one of you who will not feel many pangs of regret when he comes to leave in three, five, seven, or more years' time. If, however, you would thoroughly appreciate the joys of being a Guy's man you must enter fully into its life; this means that you should not only use it as a means to your present goal, a registrable qualification, but should also take your full share of the opportunities it offers you, for enjoyment and entertainment, whether in sport or in general culture. We would advise every man to take part in one or other of the various games which are played at Honor Oak Park, and also to attach himself to one of the societies which provide for his amusement and elevation during the winter session. The notices of the various clubs are posted in the Smoking Room and the Colonnade, and they are all only too anxious to obtain new recruits, whether they come with a reputation already made, or are only novices.

And, as a final word to you, take as your ideal the Hospital motto, *Dare quam accipere*, and we can promise you several very happy and useful years in the immediate future.

Passim.

AS we have already announced in these columns, a Dinner will be held on October 1st, to signalise the opening of the new Winter Session. The place of meeting will be the Dining Room of the Students' Club, and the president of the Hospital, Mr. Cosmo Bonsor, will be in the Chair. The time is 7.30 p.m., and tickets, price 3s. 6d. each, may be obtained from the Medical School Office. The demand for tickets already exceeds the supply, and we are asked to request ticket-holders who find they will be unable to attend to return their tickets without delay to the Medical School Office, where they can be quickly disposed of.

As no doubt all Guy's men are regretfully aware Dr. Pitt retires under the age limit about the middle of October. To mark this sorrowful occasion, Dr Pitt was invited to dinner by his past House-Physicians on Wednesday, September 24th. Dr. A. J. Cleveland was in the chair, and no less than sixteen ex H.P.'s were present to mark their appreciation of their old chief. During the evening Dr. Pitt was presented with a large solid silver salver, engraved with the facsimile signatures of all his H.P.'s in chronological order.

DR. PITT makes his last round, we understand, on Tuesday, October 14th, when all members of old Pitt firms who wish to take farewell of their old "chief" will be welcomed. We hope to publish a portrait of Dr. Pitt in our next number. As we go to press we hear a rumour that there is a proposal on foot that old members of Dr. Pitt's firms should entertain him to dinner. We advise those interested to write to Dr. Pitt's H.P., Mr. T. I. Bennett.

IF one may judge from the tenor of a postcard recently received in the Superintendent's Office, some people in Australia are not altogether pleased with the doctors in that country. We note, however, that the writer makes an honourable exception of the Scotchmen; perhaps the Mc at the commencement of his name explains this. There seems to be

some advantages out there, however, if the writer is to be believed: a pound a vaccination during a small-pox scare sounds promising!

> "Send some doctors here. All are putting on big Dog. no expd. men here at all, in vaccination. Small-pox is plentiful and a sixpenny east End *Doctor or a Doctor from the City Road would get a* pound a case, from everybody. all here are Sheep Doctors—and Veternary Surgeons. Members of Parliament Lather in the shop. Barbers are M.P.s and Justices of the peace and all the rif-raf are made Ministers and M.P.s. Doctors are wanted immediately. nobody of any brains are here cept a few Scotch surgeons. Send at once a crowd.
> Secretary, McKENNA (?).
> Guy's Hospital,
> St. Bartholomew St.,
> Boro, London, S.E."

Our correspondent made at least a good guess at the name of the street.

WHAT a sad thing it is to see clever and highly gifted individuals carried away by a wave of emotion to write a farrago of nonsense upon subjects of which they are entirely ignorant. It is still sadder to see this rubbish published over their names in popular periodicals, obtaining, one fears, an additional publicity from the fact that, on other grounds, the opinions of the writer are entitled to much consideration. This rather involved sentence is the result of the perusal of an article entitled "Surgical Hysteria," by Ella Wheeler Wilcox, published in the September number of Nash's Magazine.

Mrs. Wilcox apparently believes that there is a frightful orgy of unnecessary operating going on at the present day, and supports her argument by citing, as is usual with the writers of articles of this type, half-a-dozen or more cases, in which patients have refused operation and have recovered from their trouble, such as could be collected by almost everyone in the course of a year or two. One of the cases cited is that of a carcinoma mammæ. The patient refused operation and "went directly . . . to an X-ray specialist—a regular physician of the old school who had grown with the times. He assured the lady of a cure in a year's time"!

WE are not concerned at the moment with the question as to whether a vast number of unnecessary operations are performed or not, although we do not believe for an instant that they are; the trouble which agitates us is the effect which an article of this type may have upon some of its readers. We are all of us only too familiar with the cases who have postponed seeking advice, on account of their terror of operations, till the trouble is too far advanced for any hope of cure, and we fear that this type of foolish scaremongering will tend to increase the evil. We feel strongly that writers of established reputations are under a moral obligation to take care that they do not prostitute their authority by publishing rash and ill-considered articles over their signatures.

THERE is another side, however, to the subject of the attitude of the lay journals to medical matters. In the *English Review* for September there is an article entitled "The Doctors and Venereal Disease," over the pseudonym, "Civis." Civis appears to be a medical man, and we would congratulate both him and Mr. Harrison on their courage in publishing so clear and outspoken an article upon the subject of syphilis. Our readers may gauge how fearless the writer is when they learn that the disease is not once, we believe, referred to as "the hidden plague." One would like to see the matter of this article reproduced in pamphlet form and for sale at the bookstalls for not more than one penny. It would be of immense value.

National Health Insurance Commission (England).

MEDICAL OFFICERS (BOTH SEXES).

The National Health Insurance Commissioners for England propose to appoint certain Medical Officers, of whom one will be a woman. Candidates must be registered Medical Practitioners of not less than ten years' standing, who have had experience of general practice; in the case of women (who must be unmarried or widows), seven years' standing will be accepted. The Salaries, pensionable, will be as follows: £500; after three years, £600; after five more years, £700; and after another five years, £800 per annum. Medical Officers will be required to travel, and to live at headquarters approved by the Commissioners. Forms of application may be obtained from the Secretary, National Health Insurance Commission (England), Buckingham Gate London, S.W. Letters applying for forms should be endorsed "Medical Officer" on the envelope. No applications for forms will be considered if received after 29th September, 1913.

National Heath Insurance Commission (England),
Buckingham Gate, London, S.W.
September, 1913.

The Resurrectionists.

IV.

"But I'll be yours in death altho'
Sir Astley has my heart."
Mary's Ghost, HOOD.

OF the many efforts made to induce the public to adopt a more reasonable attitude towards dissection, the devotion of those public-spirited men who bequeathed their bodies with this intention deserves to be recorded. Amongst the earliest to take this course was Dr. Messenger Monsey, who was born in 1693, and was for many years physician to Chelsea Hospital. He was a man of a very independent turn of mind, "a stubborn Whig," a freethinker, and one who, taking for his motto *Medico et Philosopho nihil indecens,* frequently wrote and spoke as if he believed it. In his later years many were the medical aspirants who sought to obtain his promise of the reversion of the Chelsea physiciancy, only to hear this terrible old man prophesy that they would die before he did, a prophecy that, as often as not, came true. It had long been his desire that his body should not be "insulted with any funeral ceremony." He had engaged Mr. Forster, the Guy's surgeon, to examine his body, but being overtaken with a serious illness in May, 1787, whilst Forster was out of London, he wrote asking W. C. Cruikshank, the anatomist, in the event of his death "to open my Carcass and see what is the matter with my Heart, Arteries, Kidnies, &c." However, he survived until December, 1788, and it was Forster, after all, who demonstrated on his body at Guy's Hospital before a concourse of the students.

Another physician, Thomas Robson Ellerby, a Quaker practising in Broad Street, who died in 1827, left instructions that his body should be "taken to Mr. Kiernan's or some other dissecting-room," and warmly recommended other members of his profession to follow his example.

Of the laymen who held the same opinion, another Quaker, Jeremy Bentham, was the most eminent. The famous jurist, who was born in 1747, had, in a will drawn up as early as 1769, left his body for public dissection. "This my will and special request I make, not out of affectation of singularity, but to the intent and with the desire that mankind may reap some small benefit in and by my decease, having hitherto had small opportunity to contribute thereto while living." It was not until June, 1832, however, that he died, full of honours, but still of the same mind; for within two months of his death he had re-affirmed his desire to be dissected, although the Anatomy Act had already taken shape and was passed on August 1st of the same year. Dr. Fordyce received the body that had been bequeathed to him, and it was "opened for the application of some antiseptic or preservative in the way of embalming" in Grainger's School of Anatomy in Webb Street, Borough, and a lecture was delivered over the remains by Dr. Southwood Smith, a friend and executor of the dead philosopher. Afterwards, "the skeleton and head, together with several of the organs" were preserved, "the two former constituting one of the most beautiful preparations ever made." The skeleton, arrayed in a suit of Bentham's own clothes is still exhibited in the museum of University College.

Doubtless many another public-spirited man was ready to make the same sacrifice. There was a retired colonel who publicly announced that he had left for dissection "that body against which the inventions of the enemies of his country had been in vain directed"; and amongst the private papers left by Sir Astley Cooper was found a lengthy document in which William Williams bequeathed his body for "the furtherance of useful knowledge in the science of anatomy."

In addition there were offers by various persons prepared, like Mrs. Gamp, to dispose of the bodies of their nearest and dearest "for the benefit of science" and for a consideration. Another "altruist" of the same stamp vainly proposed an amendment, whilst the Anatomy Act was under discussion, recommending that no person should be allowed to commence his medical studies till he had given a written promise to leave his body for purposes of dissection.

There was an echo of these legacies when the old gentleman, of whom an oil-painting still hangs in the Clinicals' Room at Guy's, bequeathed his body with the wish that it might be dissected and his portrait placed in some conspicuous corner of the hospital. The testator, a Greenwich tradesman named William Hempfield, died on the 4th of March, 1863, aged 72, and was duly dissected.

In general, public opinion on matters of history may be conveniently judged by the impression they have left upon contemporary fiction; but in the present instance the material available is disappointingly small in amount.

The resurrectionist in fiction who at once suggests himself is the "honest tradesman," Jerry Cruncher. "The Tale of Two Cities," however, was only published in 1859, although the great historical tragedy on which the story is based belongs to the last decade of the previous century.

Indirectly the French Revolution affected the history of Guy's, for the influence its later developments exerted on the mind of Astley Cooper was far-reaching in its consequences. In his early friendship with Henry Cline he had been affected by the elder man's republican sympathies, and these were afterwards fos-

tered by association with extremists like Thelwall and Horne Tooke. When, therefore, he visited Paris to attend the lectures of Desault and Chopart in 1792 he was prepared to approve the sentiments uttered by Brissot, Vergniaud, Danton, Marat, Robespierre, and others whom he heard speaking in the National Assembly. But disillusionment was inevitable after he had witnessed the excesses that followed in the later months of his stay. Amidst the general massacres he himself narrowly escaped assassination more than once, for the black clothes he habitually wore led to his denunciation as a member of the aristocratic party who were then in court mourning; and for greater security he displayed the revolutionary badge as long as he remained in France. It became his task in 1800, when his candidature for appointment as staff-surgeon at Guy's had been jeopardised by an anonymous letter rehearsing his former Jacobin sympathies, to convince Mr. Benjamin Harrison, the treasurer, that "a nasty disagreeable sensation about the throat" had already decided him to abandon his extreme political views; and we can now appreciate to how great an extent not only his own career, but the fortunes of Guy's were affected by that decision.

The "Tale of Two Cities," then, is at best only history at second-hand, and the episode of the exhumation which forms an important part of its machinery is an effort of the imagination rather than of actual knowledge. Jerry Cruncher's professional character has already been sketched in with skilful touches before his secondary occupation is definitely revealed. In his public capacity as a bank messenger it is clear that he possesses a keen eye for the physical possibilities of those with whom he is thrown in contact; Lorry, the clerk at Tellson's, is "a lean old one," Cly, the Old Bailey witness, "a young 'un and a straight made 'un"; and, when he contemplates the punishment awarded to those convicted of treason, his emotions demand utterance; "That's quartering," said Jerry, "Barbarous!" . . . "It's hard in the law to spile a man, I think. It's hard enough to kill him, but it's wery hard to spile him, sir." Other indications are given in his interest in passing funerals and in his visits to the distinguished surgeon, "his medical adviser." In the night scene in the graveyard of St. Pancras Old Church, however, Dickens goes astray. The "agricultooral character" and his two associates are represented not merely opening the whole grave, but raising to the surface the coffin itself unopened before extracting the "scientific goods" from within; a feat well-nigh impossible in the conditions under which the resurrectionists worked, and one that was widely removed from their actual practice.

From Albert Smith we might reasonably have looked for more accurate treatment, although he entered upon his medical apprenticeship in 1832 just too late for any first hand acquaintance with the business. Unfortunately his sole contribution to the subject appears to be a story in the "Confessions of Jasper Buddle, Dissecting-room Porter," contributed to the *Medical Times* in 1839-40. The tale, melodramatic and rather pointless, relates how a distressed maiden prevailed on the porter to surrender to her the body of her lover, recently hanged.

Probably in these days very few read the once popular "Diary of a Late Physician." Taste changes, and to-day only a reader more than ordinarily endowed with patience would succeed in getting very far into what is, after all, a masterpiece in unconscious revelation of self-righteous priggishness, an exceedingly valuable demonstration of the most admired sentiments in fashion at the period. Samuel Warren, the author, studied medicine at Edinburgh in 1826-27, came to London, was admitted to the Inner Temple, and "took to the Law" in the year following. The first instalment of the "diary" was written in 1829 and was published in Blackwood's Magazine in 1830. That history scarcely prepares one for solemn assertion, in the preface, that for six years he was actively engaged in the study of physic, or for the allusions to his "rooms in the Borough" in an early chapter entitled "Grave Doings." In that story, "Sir ——— and his dressers" (the baronet is evidently intended to suggest Sir Astley) are desirous of obtaining a pathological specimen from a recently deceased patient whose friends have refused their consent to a post-mortem examination. The dressers therefore repair to the graveyard, and having "cleared away *nearly the whole of the mound,*" secure their prize, and "a preparation of her heart now enriches ——'s museum." Apart from the impudent implication of Guy's, the six words in italics stamp the whole narrative as a fiction.

The writers of light verse are more helpful. We have already drawn upon Southey in referring to the patent unopenable and self-closing wrought-iron coffins. "The Surgeon's Warning" was certainly written before 1818, when it appears in an anthology of humorous verse, and may have been a reminiscence, or possibly even an actual product, of Southey's own brief career as a student of medicine, a phase that was ended before 1803.

The dying surgeon in the ballad has forebodings that the fate that has attended the bodies of others at his hands will be his own.

"I have made candles of infant's fat,
The sextons have been my slaves,
I have bottled babes unborn, and dried
Hearts and livers from rifled graves.
And my 'prentices now will surely come
And carve me bone from bone,
And I who have rifled the dead man's grave
Shall never have rest in my own."

All his precautions prove vain. The leaden shell soldered down within the iron coffin, burial within his brother's church of which the door is locked and the key removed, and the three watchmen armed with blunderbusses on guard within the vestry; all are unavailing against his own apprentices who at length secure the body and "*carve it bone from bone.*"

But Southey's is poor stuff when compared with the two polished ballads in Thomas Hood's most characteristic vein. Of these, one is a fantastic story of an undertaker's mute and resurrection man:—

"*One of those sacrilegious knaves,*
Who crave as hungry vulture craves,
Behaving as the ghoul behaves,
'Neath churchyard wall—
Mayhap because he fed on graves
Was named Jack Hall."

The other, more to our present purpose, is the pathetic ballad, "Mary's Ghost," evidently written after Sir Astley Cooper's title was conferred in 1821 and before Sir Charles Bell received his knighthood in 1830, but probably not much before the latter year. Mary's Ghost is represented bewailing the fate of her body that has been dug up and dismembered by the resurrection men. In the sixth verse it is related that her arm "*is took to Dr. Vyse,*" a practitioner of whom we know no more than the fact that his name supplies an excellent rhyme to the statement:—

"*. . . both my legs are gone to walk*
The hospital at Guy's."

In the next verse, however, we learn that the hand which had been promised to her William is to found at "*Dr. Bell's, in spirits and a phial.*" This is the celebrated anatomist, Sir Charles Bell, who came to London in 1804, joined the Hunterian School in Windmill Street in 1811, was appointed surgeon to the Middlesex Hospital a year later, and was knighted on the accession of William IV. He was elected to the head of the medical department of University College at its formation, but resigned the post very shortly after.

In the ninth verse the head of the Dean Street School of Anatomy is celebrated.

"*I can't tell where my head is gone,*
But Dr. Carpue can;
As for my trunk, it's all pack'd up
To go by Pickford's van."

And just before the end comes the allusion to Sir Astley Cooper that heads this chapter.

One other quotation, this time in prose, must be included if only for the sake of the wholesome warning—delivered ninety years ago!—which it still conveys against talking "shop" outside the hospital precincts. The "Mirror," of March 8th, 1823, transcribes from the "New Monthly Magazine" a conversation said to have been overheard "in a coffee-house near Marlboro' Street," where the anatomical school of Joshua Brookes was situated.

The dialogue opens on various medical topics, mostly in connection with the Borough Schools, and, naturally enough, the subject of bodies soon crops up:—

"*What did you give? . . . Two shillings an inch, but the cursed fellow had pulled the child's neck almost out of joint to make it an inch longer.*"

The listener could hardly have relished that, but the climax came after:—

"*I say, I don't think you have changed your dissecting coat, have you?*"

"*Hush, hush, the people in the next box will hear; they all think now it is* the woodcock, a little too gamey."

R. M. W.

(*To be continued.*)

The Christian Union.

PRESIDENT: Charters J. Symonds, Esq., M.S., F.R.C.S. Vice-Presidents: J. Lewin Payne, Esq., M.R.C.S., L.R.C.P., L.D.S., T. B. Heaton, Esq., M.B., B.Ch., A. C. Clifford. Student President: J. A. Martin. Committee: H. H. Elliot, T. L. Heath, J. F. G. Richards, C. Sherris, P. E. Jessop. Hon. Secretary and Treasurer: J. S. Wright.

The Christian Union was organised in 1848 by Drs. Habershon aud Golding-Bird, who held meetings in their houses for students of Guy's and St. Thomas's Hospital. This was the first Union formed in the London Hospitals, in each of which there is now a society. It is part of the Student Christian Movement of Great Britain.

In connection with the above Student Movement, a conference, in the form of a summer camp, is held in July every year at Swanwick in Derbyshire. At this camp there is an attendance of about 1,500. During the Winter Term conferences are held in London.

The Hospital Union holds meetings monthly from October to June. These usually take place on Thursday afternoon at 5 o'clock, being held by kind permission of the Chaplain, in the Chaplain's room, adjoining the chapel. Various speakers have kindly consented to address the meetings. Full particulars will be given in the programmes.

The opening meeting of the session of the Guy's Hospital Christian Union will be held on Monday, October 13th, at 8.30 p.m. Owing to the kindness of Mr. and Mrs. Charters Symonds it will take the form of a social evening at their house, 58, Portland Place, W. The Rt. Rev. Bishop Taylor Smith, Chaplain-General to His Majesty's Forces, has kindly consented to speak. All Freshmen are especially invited. It is hoped that a large number will accept the invitations which are being sent out.

October
1724
A TOUR
OF
INSPECTION

The Investigation of Diseases of the Genito-Urinary Organs.

ABSTRACT OF A CLINICAL LECTURE BY RALPH THOMPSON.

GENTLEMEN,—In my lecture to-day I propose to deal very briefly with the methods of examination which may be adopted in order to elucidate certain diseases of the genito-urinary organs. Many of these diseases are associated with the presence of blood and pus in the urine. It is very important that, provided the condition of the patient will allow it, a thorough examination should be made as soon as possible. If, for example, a case of hæmaturia is to be examined, a great deal of time and manipulation may be saved in examination, and a more exact diagnosis made, if a cystoscopic examination is conducted during the occurrence of hæmaturia. If the cessation of hæmaturia occurs, unless there be manifest evidence in the bladder of gross changes, such as carcinoma, it is very difficult to say, without further examination, from whence the bleeding originated. Moreover, the patient is very apt to think that, because the bleeding has ceased, there is no further need for diagnosis and treatment. Every case of hæmaturia should be examined with the aid of the cystoscope, unless there are obvious objections, and, if possible, during the attack of hæmorrhage.

A man was admitted into Astley Cooper ward with hæmaturia of such an intensity that he was quite anæmic. With careful preparation beforehand we were able to keep the fluid in the bladder clear long enough for the blood to be seen through the cystoscope pouring from the orifice of the right ureter, and for a catheter to be introduced into the left and right ureter. Practically pure blood was found coming from the right kidney, and normal urine, with the proper percentage of urea and chlorides, from the left. I performed a nephrectomy on the right side and removed a kidney containing three large calculi, and a large "adrenal rest," which was apparently malignant.

Again, I was asked by Dr. Fawcett to examine a case of hæmaturia under his care in Clinical ward. The bleeding was very profuse, but with the help of morphia administered internally, and by means also of reaching the bladder with very hot fluid, we were enabled to see a very large inoperable tumour of the bladder. On the other hand, the presence of very thick pus in the urine is no contra-indication in itself to examination with a cystoscope. A case under the care of Dr. Pitt in the medical wards illustrates this point. There was a great deal of pus in the urine, but by careful washing out of the bladder I was able to see for ten seconds, but no longer, pus welling from the right ureter in great quantities. It was impossible for anyone to see this, unless he had passed the cystoscope himself, so quickly did the fluid in the bladder become opaque, owing to the presence of pus. Let me repeat, therefore, that if in a case of hæmaturia or pyuria, a cystoscopic examination is called for, it should be conducted during the occurrence of blood or pus, and not after the bleeding, or the discharge of pus has ceased, as with some care the fluid in the bladder may be cleared sufficiently for the origin of the blood or pus to be made out simply by visual examination through the cystoscope.

[NOTE.—In connection with this question of examination during the hæmaturia, I may mention a very instructive case of hæmaturia occurring in Clinical ward only the other day. After a considerable degree of difficulty we managed to get the bladder fluid clear enough to examine the orifice of the ureter. The left one was found to be somewhat patulous, and it was thought, but only thought, that blood was leaking in small quantities from its orifice. The left ureter was catheterized, no obstruction was found, at any rate, for a distance of 25 centimetres. Very shortly after the introduction of a catheter there was a rapid escape of a considerable quantity of sanguineous urine, increased by pressure over the left renal area. This occurrence at once settled the origin of the hæmaturia.]

By means of the cystoscope we are in a better position to judge of the condition of each kidney than we were before its adoption as a scientific instrument. For we can catheterize both ureters in many cases, and make an examination of the urine flowing from each kidney. When you are about to operate on one kidney it is most important that the condition of the other kidney should be accurately known.

Now, practically there are two methods of making such an examination, which we may call the anatomical and the physiological methods. Both have their use, but whilst both are valuable there can be, I think, little doubt that the physiological method is the best.

The anatomical method consists of the introduction of opaque material into the ureter and pelvis of the kidney and the study of the shadows cast by X-rays.

[Several photographs were shown of the position of the renal pelvis, and ureter, in the living subject, made plain by the introduction of 20 per cent. collargol into the pelvis of the kidney, along an opaque metallic catheter lying in the ureter.]

Collargol is, however, apt to obscure the appearance of the urine, and is not without danger in the production of a pyelitis, but its value is shown by the following instructive case:—A policeman was admitted into Addison ward with vague renal symptoms occurring on one side. He was X-rayed, and what was considered to be a ureteric calculus was found in the skeletal pelvis. I passed an opaque catheter, and the skiagram, which was taken with the catheter in position, showed, without any doubt, that the supposed calculus was not situated in the ureter. I considered that the renal symptoms might be due to pressure of glands, tuberculous or sarcomatous, upon the ureter, and suggested that Mr. Hughes should be called in. He operated, and found masses of lymphatic glands enlarged by disease.

So no doubt the anatomical method of investigation has its use, but as it is very liable to vitiate the physiological method of investigation I prefer, at any rate, to perform the latter before the former method.

[Details of various physiological investigations were then given.]

We may now briefly consider the cystoscopic examination of tuberculous disease of the urinary tract. I should like to say here that I believe that Sir Cooper Perry was the first authority in England to teach the importance of recognizing that vesical tuberculosis was never primary, and was always associated with disease either of the urinary or the genital organs situatedf outside the bladder. He was teaching this act several years before it was generally acc epted. Moreover, it is abundantly clear, fromt his post-mortem reports, that he suspected his conception of urinary tuberculosis years before he actually taught it. I mention these facts because such teaching, based on post-mortem examination, marks a clinical discovery of first-rate importance and significance. A kidney may for a very long time be affected with tuberculous disease, and the disease may spread down the ureter to the bladder and this viscus may be affected, but it may be some considerable time before the other kidney is affected; indeed it may, and frequently does, become hypertrophied.

Now, in some of these cases what happens is this: the urine is examined and tubercle bacilli are found. There is an enlarged and painful kidney on one side, and this is supposed to be the origin of the tubercular kidney. It is cut down upon and found to be large, and in some cases much tampered with, or even removed, during the course of the operation. In the former case it may very likely go out of action, if removed it certainly will, leaving the affected kidney to carry on work which it has given up for years. So you must be careful in cases of tubercular disease of one kidney to be very thorough in your cystoscopic examination of the urinary tract, and be quite sure that not only are you operating on the proper kidney but also that you know the condition of the other kidney. In conditions such as hydronephrosis you may be forced to adopt conservative surgical treatment if you know that the second kidney is not acting well, or that the cause which has produced the renal condition on one side may not also be acting, but more slowly on the other side.

For diseases, therefore, which are apparently affecting only one kidney it is very necessary to exclude disease in the other kidney. This may be done by examining the bladder with the cystoscope, and noting the appearance of the appropriate ureteric orifice, or by passing a catheter up each ureter and collecting samples of urine from each kidney, and examining such specimens very carefully.

The Doctor in Modern Fiction.

THE haphazard reader of the present day novel and magazine must have noticed how very frequently the scientist, especially he who practises the art of healing, appears as the principal character in the plot, and occasionally is even regarded with quite marked favour. In fact, the brilliant Harley Street physician and the capable young surgeon are fast ousting the dark, handsome barrister, the author, and the Apollo-like artist, although, be it whispered, the last as seen in art galleries and exhibitions is very unusually cast in heroic mould.

In spite of this age of enlightenment, however, it appears that we can even now only touch the public by appealing to their imagination. The fantastic and unreal make their appeal readily, whereas the truth is often treated with cynicism. One has only to read the death scene as usually described to realise that this is the case. Were it not for its tragic aspect one would laugh at the ludicrous painting of it. For it is now the time when, all the other cells of the body being in a profound state of depression, a convenient area of brain tissue is still active enough to be responsible for those wonderful final death speeches, and even feats are accomplished which in health it were impossible to perform. One would suppose that towards the terminal stages of a prolonged illness, such as advancing pulmonary tuber-

culosis—probably the author's favourite theme in these matters—there is no reason why the whole nervous system should not be in a state of hypo-activity, being part of the whole depressed physical organism. In fact, it is a most beneficient condition, for had the diseased the powers of appreciation of the healthy, the additional suffering endured would be increased many times.

An interesting aspect of death is often introduced here—the idea of putting incurables out of their misery if they desire it. Lucas Malet not long ago wrote a book dealing with this subject, and Mrs. Clifford in "Mrs. Keith's Crime" also describes how a mother kills her only little daughter who is dying of consumption. But it is only in fiction that we are such devils of accurate prognosis; we know perfectly well that the absolute course of disease cannot be foreseen.

Surgical operations are always performed in the nick of time, and the surgeon is the man of prompt action and extraordinary skill. The hero in attempting to rescue the heroine's pet dog falls down a cliff of giddy heights, and is found unconscious with what may very well be a depressed fracture of the skull. There is no medical aid to hand except that of an old-fashioned country practitioner, a doler out of nauseous pills. Suddenly a motor comes into view; Frederick Forceppes, M.D., the eminent surgeon, leaps out. Then comes the immediate operation sufficiently described thus: ". . . It is over. John Fortescue lies with closed eyes, breathing quietly, etc."

Other writers rely on the *crisis* to keep one in the necessary suspense. It is as if it were a winning post, once past which Death flogs his horse in vain.

But, on the other hand, some authors are wonderfully accurate in even the minutest technical details. In "Bella Donna" the description of the subject suffering from lead poisoning is excellent, and in the "Dop-Doctor" and in the "Doctor's Dilemma" by G. B. Shaw there is a general atmosphere of medical science which shows how singularly conversant with our work some writers can be. Probably "Tono Bungay" has done more good than the publication of "Patent Medicines." Of course, an author like H. G. Wells has no difficulty in painting accurate characters of a scientific world, and Conan Doyle is also a scientist as well.

Not to be outdone in anything, the cinematograph occasionally portrays a medical scene, and on the Continent one is thrilled by scenes relating to extraordinary surgical feats flashed on canvas. It is not easy to remember how it is brought about, but one is suddenly introduced into a hospital where the little vagabond hero is going to be operated on. Naturally everything is most dramatic. The boy raises a pale face from the table and smiles cheerfully, but the surgeon anxiously shakes his head, and a nurse in the corner weeps in her handkerchief. The anæsthetic is quickly given—very quickly, in fact—and the body laid bare. The surgeon explains with graphic gesticulations how remote are the hopes of success. He feels the edge of the knife, the violins sigh and moan, and the red blood flows all round.

A vicious circle is created when an ignorant public have their cravings satisfied by sensational books and lurid newspapers full of veiled insinuations. The public ought by now to know that disease is best fought with a bright light, and that prophylaxis and treatment are much hindered when a dark mantle of hypocrisy and false morality is shed over any pathological condition. We have had enough of "social scourges" and pious aversion therefrom. "The physician on his round then comes to a sickly-looking patient. The students keenly watch the examination. Suddenly the doctor bends down to the ear of the patient. 'Yes, sir, twelve years ago'; and the physician puts down his instrument in a bowl of antiseptic." So the man with a gumma receives scant sympathy.

Then we have cant about vivisection and blatant descriptions of weird cures. Why will the lay mind trust its body so often to the care of those who appeal to their superstitions? It seems that at present the outside world is only just awakening to the wonderful potentialities of medical science, and that unfortunately faith cures, holy waters, patent medicines and such spurious things will grip for some time to come the minds of a certain class of people. There must be enough lies printed on the advertisement pages of the modern newspaper to send the whole press to purgatory.

A. S. L.

On a Pro.'s Very Reluctant Departure from "Theatres."

Of all the jobs I've ever had, the one that I like best
Is junior pro. in Theatres One to Four,
And now that I must leave them it makes me so depressed
And I just begin to like them more and more.

How I'll long to come and join you in a cup of tea at ten
On the balcony or in the nurses' room,
When all the time I'm waiting on some dirty Boro' men
Or perhaps the D and V room is my doom!

When I think of dear old Joey in the "Glass-house" doing ops.,
Or little Frankie's sweet melodious voice,
Not to mention Rudie's mornings, Chubbie's trousers or the mops;
No wonder that I really can't rejoice.

When I think of some new nurse tying on the Major's mask,
Or doing up dear Stumpie's overall,
How fiercely will I envy that lucky pro. her task,
And wish that I was back among them all.

SMILAX.

To the Students of Guy's and St. Thomas's Hospitals.

GENTLEMEN, — Everyone must work hard in that position in life in which he is, that he may keep himself and his family in a certain degree of comfort with a moderate amount of luxury, and it is the first duty of every citizen to make himself as efficient as possible in his work, to be a useful member of the community in return for the comfort, luxury, and safety which this community affords him. But the majority of you will probably agree with me that more is needed from a man by his country than this; he should also do something for which he receives absolutely nothing in return save only the satisfaction to his conscience that he is trying to make himself worthy of his fatherland and to follow those high ideals which have been handed down to him by his forefathers. Some people do this by work among the poor, others by voluntary work as magistrates or as parish councillors, others by proselytizing the heathen at home and abroad. There is yet another way which probably appeals most to the youth of the country, and which to many of them is the only way in which they can attain this ideal. I refer to the attempt to put themselves in a position to defend their country. It is with this object and in this spirit that I wish to put before you the Officers' Training Corps. Let no one join it because he enjoys it, or because he wants a cheap open-air holiday, or because it is the fashion to do so. Let every man who joins feel that he is going to give up something to do it. To give up the whole or a part of a holiday which might be more pleasantly spent at the sea or playing golf. To turn out of an evening to drill when by a day's hard work he feels he has earned an hour in an armchair with a pipe and a book. Not to say he has no time, but to make time over and above what he already does.

There are probably three classes of people who have not yet joined the corps. First, those who really believe it is wrong to take up arms even in self-defence, and who believe that the sword will be beaten into the plough-share before many years are past. Widely as I disagree with these men, I know they hold their views honestly; I know they have seriously considered the matter, and therefore I must respect them, particularly as I realize that they are mostly public-spirited men who give up their time and energy to the country in other ways, though they deny their historical duty in this. Secondly, there are those who do just enough work to keep themselves afloat—parasites who would never give up a moment's pleasure to help anyone else—finished and finite clods, untroubled by a spark, with no ambition except to get the maximum amount of comfort with the minimal expenditure of trouble. Thirdly, are those who agree with the ideals I have set out above, who admit the principle that everyone must defend his country, but who fondly imagine that no preparation for this is necessary, and that to wait till their country is in danger is all that is needed. To the first two I do not write, to the last I would appeal. It is because I believe that the majority of you belong to this class that I write this letter. I have so often been told that doctoring is the same in war as in peace, or that the speaker can ride and shoot, and no more is needed. This is a great difficulty, for to tell these men they are wrong will in no way persuade them, and to prove to them how much is necessary besides mere doctoring, riding and shooting; they must join some branch of the regular or auxiliary forces, and so a vicious cycle is set up. When a war has broken out a man cannot be trained, but a partially-trained man can apply what he has learnt and can go on teaching himself.

War is so complex now-a-days that individual courage by itself is useless. Every man must know his place in a vast organization. It is not enough merely to stand up and be shot or be shot at. *Dulce et decorum est pro patria mori*, but in the excitement of a national crisis it is, I imagine, no hard thing to do; it is far harder in dull peace, with dozens of other claims upon one's time, to try and live for one's country, and this is what the Officers' Training Corps enables us to try to do. My argument, so far, is that it is the duty of everyone, who does not in some other way do some voluntary work for his country, to join some branch of the auxiliary forces. I wish now to put before you certain reasons why you, as medical students, can best serve your country by joining the medical unit of the Officers' Training Corps, rather than any other unit. The important points are two—first as regards medicine, and secondly as regards the training of officers. It is obvious that in a military community all persons who are present in a civil state are still necessary, and, therefore, in any scheme such as that of our Territorial Force, the special knowledge of civil life can best be used by putting its owner into an analogous position in military life. The various persons may not be needed in the same proportions, the same number of lawyers will not be necessary, nor, perhaps, the same number of jewellers or horticulturalists; but there is no doubt that the same number of doctors will be wanted. In any event in which the Territorial Force would be mobilized, sickness would go up by leaps and bounds, sanitation would become vastly more difficult. The special knowledge of every man would be needed. But that special knowledge would not be enough, he must also know something about the organization of an army, of the hygiene of the march, and the regulations under which he has control of his men. If he became a mere infantryman, his special knowledge is wasted, he should therefore join the R.A.M.C. As students you can only join the Territorial Force as privates. If you join the Officers' Training Corps you enter as cadets, training to be officers. All would be necessary as officers if the Territorial Force were mobilized, many would be needed if the Expeditionary Force only were mobilized. In either event a partly trained man would be of more value than the untrained one. If you have

given up your time to your country in peace, you will be of greater value to her in her hour of need.

When you join this corps you promise to do four things; to put in a certain number of drills each year, to attend camp for one week each year, to give up one Saturday afternoon each summer for inspection, and to pass a simple examination in the subjects studied. The country relieves you of all financial responsibility by paying the cost of this training. Since, however, the Corps spends the money before it draws the grants from the War Office, you sign an agreement with the Corps to the effect that if you do not earn the money you will pay what is spent because you have broken your side of the bargain. Simple though this may sound, many seem in former years not to have understood it, and I would have no one join who does not realize that, or who does not mean to stick to his contract.

Gentlemen, if you join the corps and then do nothing you will find it very dull, you will think it is useless, you will stigmatize it as "rot"; but if you work at it you will come to believe in it, and will find in it much of value to yourself which you never expected to find. There are, I admit, disadvantages. It is often irksome to attend a drill at the end of a long day's work. To give up a large part of a short holiday will often make you wonder why you do it. You will not be without ridicule. Now, ridicule is very hard to bear, and often those feel it most who appear to do so least. Those who do least or make no attempt ever to do anything of this sort are usually the greatest critics of the Territorial Force or of the Officers' Training Corps, and it does not do to be influenced by such. Home influence is harder to resist, for there may be those around you who think you are wasting time and energy which should be devoted to your work. In spite of all these things, I would ask you to join. I feel sure you will not regret it, and am, gentlemen, yours very sincerely,

T. B. LAYTON,
Lieut. R.A.M.C. (T.),
O.C. "B" Section, Medical Unit.

Headquarters,
Guy's Hospital, S.E.

Officers' Training Corps Camp, 1913.

THE Fifth Annual Camp took place this year at Windmill Hill, Ludgershall, on the extreme eastern edge of Salisbury Plain, and near Tidworth. For the first time the medical section of the corps was entirely alone, and the opinion was general that it was quite the best camp in every way since the corps was started. The situation was excellent and the weather perfect, and with more variety in the programme of work, everything combined to make the camp a success.

The main body travelled down on Saturday, July 19th, on a soaking wet day, which did not promise well for an enjoyable time, but the weather cleared up next day and remained excellent for the whole period. An energetic advance party under Lieutenant Layton had pitched the camp in a good position on a gentle slope, and we were delighted to find that we were quite close to our old friends of three years ago —the medical section of the Edinburgh University O.T.C. Sunday was a quiet day, mostly spent after church parade in settling down and exploring the neighbourhood. Serious work started next day, the first day or two being spent, as usual, in very necessary squad, company, and stretcher drill, varied by lectures and demonstrations of equipment. The general hours were as follows: Reveillé, 5.30; First Parade, 6.15; Breakfast, 7.30; Kit Inspection, 8.30; Second Parade, 9.0; Lunch, 1.0; Third Parade, 2.0; Lights Out, 10.15. On Tuesday and Wednesday we had two very entertaining sing-songs at the Edinburgh and our own canteens respectively, the first somewhat prematurely brought to a close by a night march!! Thursday and Friday were spent in various field exercises some mile or two away from camp, superintended by Colonel James, whom we were very pleased to have with us once again. These exercises included instruction in digging field kitchens, etc., and in cooking a simple meal. The latter was not quite so successful as last year judging from the way emergency rations disappeared!! On Saturday we set out for a long march to Stonehenge, through Tidworth, Bulford, and Amesbury, some 11 miles away. We reached there about 1 o'clock, and were very glad of an hour's rest. The return journey was made via the Larkhill Aviation Camp and Amesbury again, the detour adding nearly four miles to the journey. Another halt was made at Bulford, where our cooks had prepared an excellent stew for us, and then we marched straight back to camp, having done a total distance of nearly 26 miles, which proved to be quite enough for some few men. Next day the corps attended Garrison Church Parade at Tidworth, where our khaki uniforms did not compare very favourably with the full dress of three crack cavalry regiments. Everyone was glad of the rest that followed after the strenuous march of the day before.

The second week was chiefly devoted to the working and carrying out of tactical schemes of a more advanced kind. One day was spent in practising the collection, carriage, and care of wounded from the firing line right back to the clearing hospital, and another in examining a tract of country over which fighting was supposed to be taking place in order to find out the best positions for dressing stations, hospitals, etc., and in taking compass bearings so that the work of collecting wounded might be carried on at night. A night march afterwards took place to test the accuracy of the observations and the ease with which such work could be done. The command was

several times given to the senior N.C.O.'s, which gave them excellent practice.

The Certificate A Examinations and the Inter-section Stretcher Competition also took place in the second week. Unfortunately, B Section—Thomas's and Guy's who won the cup last year, were beaten, and much more keenness and energy will have to be shown if we are to regain it next year.

Camp was struck on the Friday, and we bivouacked that night after returning stores to ordnance. This was completed next morning, and the corps entrained for London, most of us being genuinely sorry that the time had passed so quickly.

Several innovations were tried this year with great success. One was the catering and cooking being done entirely by our own men. Several members of the corps had given up many evenings during the preceding months to take a course in camp cookery, and the results were certainly excellent. Lieutenant Layton made a most energetic and efficient quartermaster, much as we were sorry to lose him as a company officer. The canteen was very well run by Hancock and Baker of the Medical School, and all the arrangements were most satisfactory. Another novelty was the carrying out of the transport by men and horses of the R.F.A. from Bulford. This was much better than any previous arrangement, and the absence of breakdowns was very noticeable. Most members of the corps will remember with pleasure the opportunities of riding afforded by the presence of trained horses in camp.

A Guy's Man in Bulgaria.

PEOPLE'S opinions differ as regards the choice of locality for a holiday; but I think my choice promises to give me one of the most interesting and possibly adventurous holidays one could have. Thanks to the kindness of Sir G. Young, I obtained an introduction to Mr. Noel Buxton, M.P., who has been of the greatest assistance to me.

I commenced making arrangements to go out to Bulgaria on August 3rd, and owing to Bank Holiday intervening, I had some delay in getting my passport and introductions from the various legations, but managed to leave England on August 7th. I think this would satisfy any American for "Hustle." Owing to the disturbed state of the near East, I was only able to book as far as Buda-Pest. From here the direct Orient line runs to Sophia, viâ Belgrade, but the line has been blown up in several places between these towns. This necessitated my going to Bukarest, and here troubles of language began, as nobody seemed to speak English or French.

I got on to Giergevo, on the banks of the Danube, but there was no steamer that evening so I had to spend the night there. In the morning (Sunday) I went to the dock, but was told there was no steamer until the next day. However, the doctor on cholera duty got a steamer for me and took me across the Roustchouk. Here I was received with the greatest kindness and courtesy by the Bulgarian officers and sent to the hotel, as there was no train running to Sophia that day.

An amusing incident happened here. A rumour got about that I was Mr. Noel Buxton, and the Prefect of Police sent an apology for not having met me personally at the boat. But even when I had explained that I was not Mr. Buxton everybody vied with each other in being kind to me, because I was an Englishman and a friend of Mr. Buxton's. I saw here the masts and funnels of the gun-boats which the Bulgarians had sunk on the approach of the Roumanians.

The next day I started at 6 a.m. for Sophia. The authorities had given me a first-class reserved carriage, but everything was in a state of chaos. The train was so full that the soldiers travelled on the roofs of the carriages. I had several other people in the carriage, including a merchant of Roustchouk and a Bulgarian Colonel. These two could not speak English, French or German, but got me food and looked after me until we got to Sophia. Between Roustchouk and Tirnovo, two villages, the line was destroyed by an earthquake two months ago. This necessitated changing trains. Tirnovo is a beautiful village. The houses are perched on the side of a steep mountain at the foot of which runs the river.

Owing to the dislocation of traffic we did not get to Stura Zagora until the following morning. Here the train stopped. The chief inhabitants (some of whom could speak English) held a sort of informal reception at the café. The village or town was most interesting, and, I believe, characteristic of an Eastern Turkish town. There was the usual large Eastern bazaar, where the smells were as numerous and various as the articles sold.

I had the interesting experience of going into a mosque. At night the minaret was lit up with lamps, which gave an effect reminding one of the White City. There are a large number of refugees in the Stura Zagora who came there when the Turks came back to Adrianople. A few days before I got there the poorer inhabitants fled to the mountains for two days on account of a rumour that the Turks were advancing north. I spent the night at a Turkish "Hotel," but could not sleep owing to the numerous varieties of live stock that had a good meal at my expense.

At 3 a.m. we went to catch the train to Sophia. It was, however, two hours late in starting. We passed through Philippolis, but had not time to explore it, arriving about 9 p.m. at Sophia. The train consisted of about 30 carriages, with three engines, two in front and one behind, but the gradient was so steep that in places we could only do 8 to 10 miles an hour. The whole country between Roustchouk and Sophia is mountainous. There are in places long, though not very wide, plains between the mountain ranges.

Sophia is a comparatively modern town, most of it being only about 35 years old. I believe it is about 1,500ft. above sea-level, and is surrounded in the distance by the Rhodupe mountains, some of the peaks being 6,000ft. to 8,000ft. high. There are lovely views of these from many parts of the town, more especially from the Hospital Joseph-Kawatcheff, from which I am writing.

On my arrival, I was treated with the greatest courtesy by the military and medical authorities, and given the option of staying in Sophia or going into the country. Though I should have much preferred the latter, the Bulgarian language is very difficult, and this I considered was a serious obstacle. After staying a night at the Hotel Bulgaries, where I met Mr. Grey Smith, of the Balkan Committee, and Mr. Frater, of the *Chronicle*, I was appointed to the Hospital Joseph-Kawatcheff.

We have 160 beds, of which 143 are occupied—all the cases are gun-shot wounds. The staff consists of Dr. Petroff (senior surgeon of the Bulgarian Army), another Army surgeon, myself, and two student-dressers. I have about 70 beds under my charge.

As regards the political situation, immediate and future, the Turks are still at Adrianople, and are advancing west and threaten to advance north. This makes it impossible for the Bulgarian Army to demobilise, though the reservists are disbanded. Until Bulgaria can demobilise, neither Servia, Greece, or Roumania will do so. So there still remains an element of danger.

It is to be hoped the Powers will soon insist on Turkey retiring behind the Enos-Media line in accordance with the treaty of London.

When I left England the papers were full of atrocities alleged by the Greeks, Turks, and Servians to have been committed by the Bulgarians. By now Mr. Bourchier, of the *Times*, will have returned to England, and people will know that the atrocities were *not* committed by the Bulgarians.

During the war between Bulgaria and the Greeks and Servians, who were joined by the Roumanians, the three latter prevented any communication between Bulgaria and the outside world. The Greeks and Servians freely published the most impossible lies about the Bulgarians as regards their burning villages, killing prisoners, and committing other outrages. Mr. Grey Smith, of the Balkan Committee, and others are most carefully investigating these allegations. I myself have interviewed many refugees. There is not the least reason to think that the Bulgarians have behaved in any way except the most humane.

On the other hand, there is abundant evidence that the Greeks have burnt villages, killed and mutilated thousands of prisoners, and have committed other outrages. Through the courtesy of the foreign minister I have the *fac-simile* copies of the letters in the Greek mails captured by the Bulgarians. The atrocities which the Greeks admit in these they have committed are outrageous. The fact that Bulgaria is full of Turkish, Greek, and Servian refugees is in itself sufficient evidence that they are regarded as the protectors of these people. This fact is hardly compatiable with the fictions invented by the Greeks, Turks, and Servians.

During the last month the statistics of the Hospital Joseph Kawatcheff are, roughly, these: 274 admitted for bullet and shrapnel wounds, 128 discharged cured, 8 removed to other hospitals, 2 for cholera, others for special eye diseases, 4 deaths, 55 operations. When we demobilised, those remaining were sent to convalescent institutions and removed to other hospitals. I have previously omitted to say that the nursing is entirely done by ladies resident in Sophia. The nurses in the operating theatre and dressing rooms are excellent. In the wards something more could be desired as regards cleanliness, etc. But to quote the French saying, "La guerre comme la guerre." Many of the men are terribly mutilated with wounds, the worst being those caused by shrapnel casing. Several have two or more separate bullet wounds.

When the Hospital Joseph Kawatcheff demobilised, Dr. Petroff very kindly asked me to join him at the Alexander Hospital—which is the large general hospital at Sophia. I, however, wished to go further afield, so I saw Dr. Orahowatch, the medical director for the war, who offered me any post I might like to take. I decided to go into the country and form a little "commission" for the government and myself. Accordingly, the next day at 6.30 a.m. an interpreter arrived, who took me to the station. We bought some food and caught the 8 a.m. train to Radomir. Here a motor should have met me, but as often happens in this country, it had been forgotten, so we drove to Dupnitza, a distance of about 45 kilometres. I reported myself at the hospital (converted artillery barracks), but as almost all the wounded had been discharged and the two doctors were quite able to deal with the cases of typhoid fever, I decided at once to start my commission amongst the refugees. The guest chamber at the hospital was not ready that night, so we had to sleep (?) at the "Hotel." The bugs and fleas were as vicious as those I met at Zara Zagora and I got no sleep.

The next day the General sent a huge motor ambulance for me, and with my interpreter we started away in a south-westerly direction toward the old Macedonian frontier. On leaving the town I passed the graves of a large number of soldiers who died of cholera during the war. Then we passed some thousands of refugees (Macedonian chiefly) who had started their journey homewards. One tiny girl had sore feet and could not walk, so I took her along in the ambulance and returned her to her family some 20 kilometres further along the road where they were waiting for us in the evening. The road was much cut up owing to the troops and guns having passed over it going to Macedonia. We left the main road and went to a very pretty village on the Struma

called Bosboshevo. Here I interviewed some refugees, and had dejeuner at a house where we were received most hospitably. Then I rejoined the main road and went to the mountainous villages of Kocharinova and Rila.

Here I obtained some revolting and terrible statements of Greek atrocities. My visit was quite unexpected and nobody had previously interviewed these refugees; also they had no idea of the object of my visit. Consequently, I consider the statements I obtained of particular value. I shall be pleased to show either the signed originals in Servian or the translations to anyone who may be interested. From there I took the opportunity to go to a monastery about 42 kilometres up the mountains. The road was little better than a bare track. We followed a mountain torrent all the way up. The scenery was indescribably beautiful. The monastery is, I believe, the largest in the world, built within a few hundred feet of the snow level. The peaks all round were covered with snow. Graves by the roadside testified to the loneliness of the road up to the monastery.

The King of Bulgaria once went to the monastery in a motor, but with this exception the car I was in was the only one that has been up this track. As the river had washed away the road in many places, the drive was not without excitement. We got back to Duplitsa at 10 p.m. Though the guest-room at the hospital was bare and the windows broken, I was glad to spend a good night without bugs or fleas. The next day I went to Kustenderel, which I explored, and caught a train which, being four hours late, arrived at Sophia at 2 a.m. When it got dark I had to leave my carriage and travel on the platform outside, as the fleas nearly drove me mad. During this trip I passed through part of the best tobacco district. Every sunny wall, even those of churches, was festooned with garlands of leaves drying.

The next day I called on the authorities, and as there was no more urgent medical work to be done, I settled up my affairs. I started for home via Belgrade. I left Sophia at 11 p.m. with Major Plunkett, our military attaché, and others who were going to Macedonia to inspect the battle-fields. At 2.30 we arrived at the Servian frontier. Here the bridge was destroyed and we had to get out of the train. The Servian train did not arrive for another 3½ hours, and we had to wait in a damp marshy place at the side of the line until it arrived. We were able to buy some bread at one of the stations, off which, and some coffee out of a Thermos flask, we made our breakfast. At Nisch we parted company. I had to wait 4 hours for the train for Belgrade, and when it came in it was a free fight to get even standing room in it. Being packed like sardines in even the corridors and platform of the carriage, I stood till 8 a.m. next morning till we reached Belgrade. I had a wash and explored the town.

The palace where Alexander and Draga were murdered in 1902 has been pulled down, but I was pointed out one of the officers who took part in this tragedy.

As I wanted to hear about the war from the Servian point of view, although my time was short. I quickly made friends with several correspondents and other influential people, who freely expressed their opinions to me. I here found that whatever opinions the Servians have of the Bulgarians, they agree that the Greeks committed the most frightful atrocities.

After being medically inspected for cholera, we passed over the Danube to the Hungarian frontier. Here we were again medically inspected, and being allowed to pass, I got on to Buda-Pest. The following morning I picked up the Orient Express at Vienna, the luxury of which was a striking contrast to some of my experiences of the last few weeks

G. W. C. HOLLIST.

From Clinical.

Two Cases of Atropine Poisoning.

CASE I.

George W., aged 2 years, 8 months, was admitted to Miriam Ward at 8.30 p.m., on August 12th, three hours after having swallowed the contents of a drop-bottle containing a solution of atropine (gr. iv. to ℥ i.). He was said to have swallowed about a teaspoonful and a half of the solution, which would have contained gr. ½ of atropine.

On admission he was in a comatose state, with rather noisy respiration; if disturbed, he awoke and screamed loudly and shrilly and persistently, throwing about his arms and clutching at his mouth and at imaginary objects, but quickly relapsing into coma when left alone. The face was deeply flushed, the pupils widely dilated, the pulse was rapid, varying between 120 and 170; the mouth was dry and contained a whitish sticky secretion. The lachrymal secretion was completely inhibited, and the eyes required frequent washing out. The patient was given castor oil, and morphia gr. $\frac{1}{12}$. This latter did not slow the pulse to any appreciable extent, and the fits of delirium and screaming continued at frequent intervals. Pilocarpine gr. $\frac{1}{12}$ was then given; three hours later the pupil contracted to about half its former size, the pulse became slower, and the patient slept quietly.

During the night the temperature rose from 98·4° to 107°, but quickly came down again to normal. Twenty-four hours after admission signs of visceral paralysis became evident. There was absolute constipation and retention of urine, and the abdomen was considerably distended. The patient was given pituitary extract ♏vii. hypodermically, a turpentine enema, and aqua anethi by the mouth. Soon after this the bowels were opened freely, and a large quantity of food, which must have been in the stomach for at least twenty-four hours, was

vomited. The following day the symptoms had for the most part disappeared, and the patient made a good recovery.

A specimen of the urine when dropped into a cat's eye failed to produce any dilatation of the pupil.

A. C. C.

CASE II.

Thomas K., aged 8½ years, was admitted into John at 9.15 p.m. on August 22nd for belladonna poisoning. No history could be obtained as to how the patient managed to get the poison, except that another boy had given him some sweets known as Dr. Spanish. This particular sample of Dr. Spanish had not the appearance of the usual article, as the boy friend said he had melted it down; still, despite its appearance, it was irresistible to the patient, who ate it all, and returned home for tea. During tea the patient's face became flushed, his mouth very dry, and he was unable to swallow. He was placed in an armchair, and soon became very restless, talked nonsense, and appeared to catch imaginary objects. A chemist was consulted, and finally a doctor, who immediately sent him up to the hospital.

The patient was seen in the surgery at 9 p.m. His face was very flushed, the pupils were widely dilated, and the lachrymal secretion was absent; and the mouth dry. He was unconscious, delirious, and catching at imaginary objects. He vomited once.

On admission into the ward 1/6 gr. morphia was given, and the stomach washed out with sodium bicarbonate. The washout contained large pieces of undigested meat and French beans, which patient had had for his dinner in the middle of the day. A drop of the vomit was put in a cat's eye, but no dilatation occurred after twenty minutes.

During the night the abdomen began to swell; a turpentine enema was given, with the result that much flatus was passed and with it the distension disappeared.

The pulse on admission was 106 and quite regular, but on the following morning the rate was 72, and every fifth beat was missed; by the evening the pulse was quite regular again.

There were three interesting points which helped to confirm the diagnosis:—(1) Eighteen hours after the patient's last meal undigested meat and French beans were vomited. (2) The pupils remained dilated and inactive to light for three days. (3) Constipation was most marked and the bowels were not opened for four days, although castor oil was given on two occasions.

The patient made a perfect recovery, and was discharged on August 26th. It afterwards appeared that the boy friend had been exploring a chemist's rubbish heap, and had found a material which looked like Dr. Spanish. This material must have been some preparation of belladonna, and was eaten by the patient. The boy friend ate none.

E. M. M.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—ED., G.H.G.]

SIR,—Perusal of the letters of my old friend Larkin in the last two numbers of the GAZETTE, has revived the wonder I have previously felt, that a man, who could do such work for the science and advancement of surgery, should have achieved so little for himself.

It must be remembered that he was actually the originator of renal surgery in days when interference with any abdominal viscus was looked on as fatal, and even simple ovariotomy as quasi-criminal, before the days of Spencer Well's forceps, and modern hæmostatics, and when cleanliness was so little understood that hands were washed after, and not before, operations; when sponges were used from case to case, when hospital gangrene and erysipelas were rife, and when asepsis, antiseptics, and Listerian surgery were undreamed of.

As an unqualified student in his third year, he excised some 30 or 40 kidneys successfully, and paved the way to success for Durham, Lucas, and all successive surgeons. Unluckily his early education, like that of so many a good man, was so defective that the preliminary arts examinations for the higher qualifications were impossible for him, while the *res augusta domi* compelled him to turn his knowledge into bread and butter by the shortest and easiest route.

Nowadays, even in England, means would be found to prevent so lamentable a loss of talent, and, therefore, I am tempted to ask if it be too late for the Colleges or Universities to remedy even now the injustice of poverty, and to honour themselves by enrolling the name of F. G. Larkin on their honorary list.

Probably his innate modesty will resent this suggestion, the *mens conscia recti* being sufficient reward for minds of his calibre, but I am sure that you, sir, will not consider a small portion of your paper wasted in the publication of this idea from—Yours, &c.,

Sept. 15th, 1913. A GUYITE OF 45 YEARS AGO.

Change of Address.

Mr. R. O. Moon has removed from 45, Green Street, W., to 62, Montagu Square, W.

H. F. Stephens, M.R.C.S., L.R.C.P., from Wyke House Asylum, Isleworth, S.W., to Earlswood Asylum, Red Hill, Surrey.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Reviews, etc.

Aids to Surgery. By Joseph Cunning, M.B., B.S., F.R.C.S. Third edition. Messrs. Baillière, Tindall & Cox. Price 4s. net.

The fact that this volume has run into a third edition is a proof, one supposes, that there is a demand for books of this class; it is a matter of constant wonder to know wherein the attraction lies. Perhaps there is some magic in the title suggesting that between the uninteresting brown covers lies a short cut—not, perhaps, to knowledge—but to the next best thing, diplomas. Or, perhaps, because the volume is small and of a convenient shape—"handy" would be an appropriate term—the mathematical man reasons that since it is possible to read twenty pages of matter in an hour, it is better to read twenty pages of compressed surgery than a similar number from an ordinary "padded" text-book. What the attraction is one does not know, but it exists, undoubtedly, and the volumes on every possible aspect of medicine and surgery which may be found in the series are irrefutable evidence.

The more one examines the more one wonders that it has any sale. Picture yourself reading surgery in a book crammed with small, close print and with no illustrations of any sort, not even a diagram! No wonder some men find it such a dull subject. Although we thoroughly disagree with the idea of "cram-books," and disapprove strongly of their use, it is only fair to say that we have found the descriptions of those conditions we have looked up to be accurate and up to date, and commendably full.

The British Journal of Surgery. Vol. I., No. 1. Messrs. John Wright & Sons, Ltd., Bristol. Price 7s. 6d. net.

We congratulate the originators and producers of this new journal on their enterprise in bringing out at last a periodical worthy of British surgery, and able to hold up its head beside the "Quarterly Journal of Medicine." It has long been needed, and will, we hope, achieve immediate success. The paper and printing are excellent, as also is the reproduction of the illustrations. We hope the editors will encourage authors to illustrate their papers as much as possible. Verbal description is a lost art.

Very appropriately the frontispiece is a portrait of Lord Lister. We notice especially an article by Mr. Rendle Short on Surgical Shock which is a very clear and succinct review of current theories with criticism. It forms a very useful introduction to a further study of the subject. There is also a critical article by Mr. F. E. Shipway on Recent Methods of Anæsthesia, which is helpful in view of the numerous modifications which have been introduced in recent years. The section on Visits to Surgical Clinics reads rather like the description in a parish magazine of a Sunday School Treat. Unless criticism is allowed, the section might as well be dropped at once for all the value it will have.

John Hunter and Odontology. By J. F. Colyer, L.R.C.P., M.R.C.S., L.D.S., Dental Surgeon to the Royal Dental Hospital of London and to the Charing Cross Hospital; Examiner in Dental Surgery, Royal College of Surgeons of England; Hon. Curator Odontological Collection of the Museum of the Royal College of Surgeons of England. Illustrated. Messrs. C. Ash, Sons & Co., Ltd., Broad Street, Golden Square, London, W. Price 21s. net.

This handsome volume makes a very interesting addition to the literature of odontology, and will be welcomed by a large circle of general readers, besides those especially interested in the history of dentistry or in the work of John Hunter.

In the autumn of 1912 the author gave some demonstrations at the Museum of the Royal College of Surgeons on specimens of teeth prepared by John Hunter, and in response to a request that an illustrated description of the demonstrations should be published, the present work has appeared. It is, however, much more than a description of the specimens, an account of Hunter's life has been included as well as chapters on his work in pathology and comparative dental anatomy, and the whole forms "a general account of Hunter's contributions to odontology.

Mr. Colyer is particularly well fitted for his task, and while many others would have produced merely a rather uninteresting catalogue, he has so made the dry bones live that, under his expert guidance, the reader will spend a very pleasant and instructive hour with these old-time specimens and books, and he will as likely as not come away with the feeling that John Hunter was quite one of the moderns, as, indeed, he was.

Chapter 1 is devoted to a very interesting account of Hunter's life. We see the man just as he was, quick-tempered, indefatigable in the pursuit of his favourite studies, and in the acquisition of material for investigation, and, it must be said, at times a difficult colleague to work with.

Chapter 3 treats of "Teeth in General," and chapter 4 of the "Anatomy of the Human Teeth." Many many of the specimens figured and described are very beautiful ones; especially striking, perhaps, are those showing the relation between the various parts of the growing complex teeth of the horse and elephant. On pages 54 and 55 are illustrations of the "madder feeding" experiments by which Hunter discovered the method of growth of the lower jaw. Very interesting, too, are the specimens illustrating the development of

the teeth, together with extracts from Hunter's "Natural History of the Teeth," which, to quote Mr. Colyer's words, "give a vivid picture of the progressive growth of the teeth." In fact, the present-day reader cannot help being astonished both at the "freshness" of the descriptions and at the wonderful progress that Hunter made in the science of odontology without the aid of our modern methods and appliances.

Chapter 5 treats of the pathology of the teeth. Figures are given of specimens showing caries, exostosis, alveolar abscess, and other conditions, and on page 168 is an illustration of the famous "tooth implanted in a cock's comb" which, as Mr. Colyer points out, does not show any true union at all. Although Hunter was mistaken in this particular instance, the reader cannot fail to be struck with the general accuracy of his observations and the soundness of his conclusions. His treatment, moreover, was, to quote the author's words once more, "always based on the anatomical and pathological knowledge of the parts involved, and in that respect it was rational and not empirical."

Chapters 6 and 7 deal with comparative dental anatomy and the pathology of teeth in animals.

Nursing of Infectious Diseases. By F. J. Woollacott. The Scientific Press, Ltd. Price 2s. 6d. net.

This book should be a valuable help to nurses engaged in fever nursing. It is thoroughly up to date, and describes the probable course and treatment of each disease in a clear and comprehensive manner. Excellent practical directions are given for most of the nursing treatment, but the method described for the administration of a nasal feed is not altogether to be recommended. There is a useful chapter on the antitoxin treatment of diphtheria.

University of London Officers' Training Corps.

Medical Unit. "B" Section.

NOTICES.

1. Classes for Certificate "A" will be held on Thursday afternoons at 5 p.m. alternately, at Guy's and St. Thomas's, beginning in Class Room No. 2, Guy's Hospital, on October 2nd.

2. Men wishing to join should come and see me in the Dissecting room on Friday, October 3rd, at 10 a.m.

T. B. LAYTON,
Lieut. R.A.M.C. (T.),
O.C. "B" Section.

Notices.

University of London.

UNIVERSITY COLLEGE.

FIRST TERM. SESSION 1913–14.

A public lecture on "The Scope of General Physiology" will be given by Professor W. M. Bayliss, M.A., D.Sc., F.R.S., on Friday, October 3rd, at 5 p.m.

WALTER W. SETON, M.A.,
Secretary,
University College, London,
Gower Street, W.C.

Appointment.

Military.

G. W. C. Hollist, M.R.C.S., L.R.C.P., to be Commandant of the Maidenhead Company of the Berkshire National Reserve.

PAPERS RECEIVED.—Nursing Times, The Hospital, Clinical Excerpts, St. Bartholomew's Hospital Journal, Clinical Journal, Medical Review, Public Opinion.

Sport.

Football Fixtures.

Date. 1913.		RUGBY.—FIRST FIFTEEN.	
Oct.	4	Catford Bridge	Home
	11	U. C. S. Old Boys	Home
	18	Old Blues	Home
	22	Cambridge University	Home
	25	Rosslyn Park	Home
	29	Oxford University	Away
Nov.	1	Streatham	Home
	8	London Welsh	Away
	15	London Irish	Away
	19	United Services	Away
	22	Harlequins	Home
	29	Northampton	Away
Dec.	6	Richmond	Home
	13	*Bedford*	Away
	20	Old Millhillians	Home
1914.			
Jan.	3	Rosslyn Park	Away
	10	Blackheath	Away
	14	Newton Abbot	Home
	17	Old Merchant Taylors	Away
	24	London Scottish	Home
	31	Catford Bridge	Away
Feb.	3	Guy's v. Thomas, 1st Rnd Cup Tie	R'mond
	7	London Welsh	Home
	11	Cambridge University	Away

14	United Services...	... Home
19	2nd Round Cup Tie	... R'mond
21	Coventry	... Away
26	Semi-Final Cup Tie	... R'mond
28	Old Leysians	... Away
Mar. 7	Old Crocks	... Home
12	Final Cup Tie	... R'mond
14	Newton Abbot	... Away
21	Old Alleynians	... Home

1913. SECOND FIFTEEN.

Oct. 4	Chartered Banks	... Away
11	London Scottish "A" ...	... Away
15	University College	... Away
16	King's College, Canterbury ...	... Away
18	Rosslyn Park "A"	... Away
Nov. 1	Streatham "A"	... Away
8	Central Technical College ...	... Home
15	Old Merchant Taylors "A" ...	... Away
22	London Irish "A"	... Away
29	Richmond "A"	... Home
Dec. 6	African Banks	... Away
13	Old Blues "A"	... Home
20	Blackheath "A"	... Away
1914.		
Jan. 3	London Welsh "A"	... Away
10	Rosslyn Park "A"	... Home
31	King's College	... Home
Feb. 21	African Banks	... Home
28	Old Blues "A"	... Away
Mar. 7	London Irish "A"	... Home
14	London Welsh "A"	... Home
21	Central Technical College ...	... Away

1913. THIRD FIFTEEN.

Oct. 11	Walton I.	... Away
15	R.M.A. II., Woolwich ...	... Away
18	Old Storfordians "A" ...	... Away
22	Dulwich II.	... Away
29	Bart.'s III.	... Home
Nov. 1	Ludgate Circus	... Away
5	St. George's Hospital I. ...	... Away
12	Berkshire Wanderers	... Away
19	St. Mark's College	... Away
22	Christ's Hospital I.	... Away
26	R.M.A. II., Woolwich ...	... Away
Dec. 3	King's College School... ...	... Away
6	Tonbridge "A"	... Away
13	London Hospital III.	... Away
1914.		
Jan. 10	Walton I.	... Away
24	St. Mark's College	... Away
28	Christ's Hospital I.	... Away
Feb. 4	Dulwich II.	... Away
11	Bart.'s "B"	... Away
18	Berkshire Wanderers	... Away
25	St. George's I.	... Away
Mar. 7	Richmond II.	... Away

1913. NOMADS.—FOURTH FIFTEEN.

Oct. 11	United Services College ...	... Away
18	Christ's College	... Away
29	Dulwich College III.	... Away
Nov. 1	Bedford Modern School ...	... Away
15	London Hospital "C" ...	... Home
26	Mill Hill School III.	... Away
29	Walton II.	... Away
Dec. 3	Whitgift Grammar School ...	... Away
1914.		
Jan. 4	Upper Clapton "B"	... Away
Feb. 21	Dulwich College III.	... Away

1913. ASSOCIATION.—FIRST ELEVEN.

Oct. 25	Clapham Rovers	... Away
Nov. 1	Middlesex Asylum	... Away
5	Emeriti	... Home
8	Wellingborough Old Boys ...	... Away
15	Bank of England	... Home
22	Old Owens	... Home
26	Casuals	... Home
29	Old Cranleighans	... Home
Dec. 6	Ilford Avenue	... Home
20	Old Citizens	... Away
1914.		
Jan 3	Beckenham	... Away
10	Ilford Avenue	... Away
14	Emeriti	... Home
17	Bank of England	... Away
28	Casuals	... Home
31	Old Cranleighans	... Away
Feb. 7	Clapham Rovers	... Home
14	Old Owens	... Away
21	Middlesex Asylum	... Away
Mar. 7	Bradfield Old Boys	... Home

1913. SECOND ELEVEN.

Oct. 18	Horton Asylum	... Away
25	Old Quermorians	... Home
29	St. Thomas's II.	... Home
Nov. 15	Bank of England II.	... Away
22	Clapham Rovers II.	... Away
29	Old Cranleighans II.	... Away
Dec. 6	Old Quermorians	... Away
1914.		
Jan. 3	Clapham Rovers	... Home
17	Bank of England II.	... Home
31	Old Cranleighans II.	... Home
Feb. 28	St. Thomas's II.	... Away

Birth.

LEEMING.—On August 20th, 1913, at "Cilgwyn," Old Colwyn, North Wales, to Dr. and Mrs. Norman Leeming, a son.

Marriage.

DEPREE—WILLEY.—On Tuesday, September 16th, at the Cathedral, Exeter, by the Bishop of Marlborough, Dean of Exeter, Hubert T. Depree, M.B., B.C., son of Mr. and Mrs. F. Templer Depree, Newlands, Exeter, to Lilian May, eldest daughter of the late H. A. and Mrs. Willey, Pennsylvania Park, Exeter.

Death.

WALLACE.—On September 3rd, at his residence, 5, Willingdon Road, Eastbourne, from sudden pulmonary hæmorrhage, Richard Teale Wallace, M.R.C.S. Eng., L.R.C.P. Lond., only son of Richard Unthank Wallace, M.B. London, of 133, Clapton Common, aged 49 years.

Lectures* for Sessions 1913—1914.

WINTER SESSION. OCTOBER—MARCH.

†	LECTURERS.		DAYS.
Anatomy (1st & 2nd)	Mr. Fagge and Mr. Rowlands	9	— Tu W Th — —
Microscopical Pathology (3rd) ...	Dr. Laidlaw, Dr. Eyre & Dr. Johnson...	2.30	— — W Th(10) — —
Pathological Classes (3rd & 4th)	Dr. Laidlaw and ...	—	— W(11.30) Th(9.15) Sat(11)
Bacteriology (Jan. to Mar.) (4th)	Dr. Eyre and Dr. Lucey	4	— Tu — — — —
Practical Obstetrics (3rd & 4th)	Mr. McNair (Oct. and Jan.)	11.30	— — — Th — —
Chemical Physiology (Jan.) (2nd)	Dr. Pembrey, Mr. Ryffel, Dr. Kennaway, and Mr. Marshall.	11	— — — — Fri Sat
Chemistry (1st and pre. sci.) ...	Dr. Lowry	9.30	— Tu — Th — —
Practical Chemistry	Dr. Lowry, Mr. Merriman and Mr. Rogerson	10.30	— Tu — Th — —
AdvancedPracticalPhysiology(3rd)	Dr. Pembrey, Mr. Ryffel, Dr. Kennaway, and Mr. Marshall	11	M — W — — —
Practical Medicine (3rd) ...	Mr. Mutch, Mr. Barber, Mr. Heaton, and Mr. Poulton	—	———
Experimental Physics (pre. sci.)	Dr. Fison	3	M Tu — — — —
Chemical Physics (1st)	Dr. Fison and Mr. Abram	11	M — — — Fri (2) —
Practical Surgery (3rd)	Mr. Gardiner and Mr. Todd	12.30	— Tu — — Fri —
Physiology (2nd)	Dr. Pembrey (Oct.-Dec.)	10	M — W — — Sat
Clinical Medicine (3rd & 4th) ...	The Physicians	1.30	— — W — — —
Surgery (3rd)	Sir Arbuthnot Lane, Mr. Dunn, Sir Alfred Fripp and Mr. Steward	9.30	M — — — Fri —
Clinical Surgery (3rd & 4th) ...	The Surgeons	1.30	— — W — — —
Elementary Biology (1st) ...	Mr. Assheton, Mr. Reed & Mr. Bromley	10.45	— — W Th(2) Fri —
Morbid Anatomy (3rd & 4th) ...	Dr. French, Dr. Cameron and Dr. Hunt	2	M Tu W Th Fri Sat(12)
Medicine (3rd)	Dr. Hale White, Sir C. Perry, Dr. Shaw and Dr. Fawcett	4	— — W (3) — Fri —
Ophthalmic Surgery (Jan.) (4th)	Mr. Eason	4	— — W — — —
Public Health (Jan.) (4th) ...	Dr. King Brown	4	M — — — Fri —
Anæsthetics	Mr. Rowell (Dec.)	—	———
Dental Surgery and Pathology...	Mr. Wynne Rouw	4	— — — Th — —
Metallurgy	Dr. Lowry...	4	M — — — — —
Practical Dental Metallurgy ...	Mr. Pearce (Jan.)...	2.30	— Tu — — — —
Dental Anatomy & Physiology...	Mr. Hopson	4.15	— — W — — —
Dental Mechanics	Mr. Lewin Payne (Oct.–Dec.)	4	— Tu — — — —
Practical Dental Mechanics ...	Mr. Pillin (Jan.)	2.30	— — — — Fri —
Pathology	Dr. Laidlaw	12.30	— — — Th Fri —

SUMMER SESSION. MAY—JULY.

†	LECTURERS.		DAYS.
Medical Jurisprudence (3rd & 4th)	Mr. Ryffel	10	— — W — Fri —
Midwifery (3rd)	Mr. Bellingham Smith and Mr. Chapple	9	— Tu W Th — —
Diseases of Women	Mr. Bellingham Smith and Mr. Chapple	9	— — — — Fri —
Mental Diseases (3rd)	Dr. Craig	9.30	M — — — — —
Bacteriology (April to June) (4th)	Dr. Eyre and Dr. Lucey	4	— — W Th — —
Practical Obstetrics (3rd) ...	Mr. McNair	11.30	— — — Th — —
Biology and Botany (pre. sci.) ...	Mr. Assheton, Mr. Reed & Mr. Bromley	2	— — W — Fri —
Physiology (2nd)	Dr. Pembrey	9.30	M — W — — Sat
Histology (1st)	Dr. Pembrey, Mr. Ryffel, Dr. Kennaway, and Mr. Marshall	10.30	M — W — — Sat
Practical Surgery (3rd)	Mr. Gardiner and Mr. Todd	12.30	— Tu — — Fri —
Practical Medicine (3rd) ...	Mr. Mutch, Mr. Barber, Mr. Heaton, and Poulton	12	— — — Th — —
Experimental Physics (pre. sci.)	Dr. Fison and Mr. Abram	1.30	M Tu — — — —
Clinical Medicine (3rd & 4th) ...	The Assistant Physicians	1.30	— — W — — —
Clinical Surgery (3rd & 4th) ...	The Assistant Surgeons	1.30	— — W — — —
Morbid Anatomy (3rd & 4th) ...	Dr. Fawcett, Dr. French & Dr. Cameron	2	M Tu W Th Fri Sat(12)
Therapeutics	Dr. Beddard	4	M Tu — — Fri —
Anæsthetics	Mr. Rowell (June)	—	———
Operative Dental Surgery ...	Mr. Parfitt	2	— Tu — — — —
Chemistry	Dr. Lowry	9.30	— Tu — Th — —
Practical Chemistry	Mr. Merriman and Mr. Rogerson ...	10.30	— Tu — Th —Sat(10)
Exp. Pathology (Gordon Lectures)	Dr. Laidlaw	12.30	— — — — Fri —
Pharmacology	Dr. A. J. Clark	—	———

* No effort has been made to include the many demonstrations or practical work.

† The numbers in this column refer to the years in which this course should be attended.

The Sciences.

Anatomy and the Dissecting Room.

The primary object of dissecting is to learn anatomy. By seeing the structures lying in their proper relations one to another a mental picture is obtained which cannot be had by reading or looking at pictures; by cleaning these structures and tracing them from above downwards their course is impressed on the mind; and by removing each muscle from its attachment these facts are learnt which have been taken for granted when first reading the bone.

In addition dissecting trains the fingers and develops the sense of touch, and that delicate muscle sense which is so necessary to aid the eye in carrying out a delicate manipulation.

The basis of anatomical knowledge is a thorough acquaintance with the bones. These can only be learnt by handling the bone and making out each point on it as the description in the book is being read. Hence it is absolutely essential to buy a half skeleton and a disarticulated skull. (These may be had from Hancock, the dissecting-room porter, who will also supply apron and sleeves—price 2s. 6d.—and cases of instruments).

The man who sits in an easy chair with an open Gray upon his knees and no bones by his side is simply wasting his time.

Books and Instruments.

The student must have two books of anatomy, the one to read it systematically by starting with each muscle, nerve, or other structure, the other to read it topographically as each structure is exposed in the course of dissection.

The book for the latter is Cunningham's Practical Anatomy (2 vols., 10s. 6d. each); it should be taken into the room and read before, during, and after each day's work.

The best books for the former are Gray's or Cunningham's Anatomy. Those reading for higher examinations might also get Quain's Anatomy, of which the eleventh edition is now appearing in parts. These will also need at some period a book on Embryology. The best book on this subject for students is Keith's as it is written from a surgical point of view.

The following instruments are necessary:—Three scalpels, two pairs of *dissecting* forceps, and two sets of "hooks." No other instruments are necessary, and the small forceps used in the biological department are worse than useless.

How to begin Work.

The following rules will help:—

1. Bring up an old coat, and procure an apron and sleeves. These keep you clean. Men are sometimes seen dissecting in their everyday coat, or in their shirt-sleeves without rolling them up. The cuffs and arms then get sodden in fat and body fluid, which substances are transferred in the evening to the dinner cloths of the student's parents or landlady. Such dirty habits need no comment.

2. Deposit 5s. at the Medical School Office and procure the key of a locker in which to put these and other requisites for dissection.

3. Attend at 12 noon on Monday, October 2nd, the introductory demonstration given by the Senior Anatomy Demonstrator. You will there be given a "Red Book" containing the rules of the dissecting-room, and will be told in greater detail than is possible here, the ways of the room and the work to be done.

4. In the afternoon of October 2nd look for your name on one of the lists, and find out what part has been allotted you. Then find out the times of the bone and other classes which correspond to this part. They are held by Mr. Mullally and Mr. Bromley.

5. Either that afternoon or early next morning begin dissecting, and remember

(i.) Not to be in a hurry.

(ii.) To read carefully in your book (Cunningham) the pages describing the surface markings of the part, and the lines of incisions that must be made.

(iii.) To turn back *the skin only*, leaving the fat upon the body.

(iv.) To remove carefully this fat, leaving intact the white layers of "deep fascia" which cover the muscles.

(v.) To clean the surface of the muscles. Cut with the grain or muscle fibre, and clean it *right up to its attachment to the bone.*

(vi.) Always read ahead of your dissection, either in the pickle-room, or wax-model museum.

PHYSIOLOGY.

Physiology, which forms the basis upon which scientific medicine and surgery rest, will require the most earnest attention on the part of the student during the short space of two years which he can devote to it, and he will find that his understanding of the medical, surgical and pathological problems with which he will meet later on varies directly with the thoroughness of his physiological ground work. While attendance at physiology lectures and the reading of some elementary work on the subject, such as Huxley's *Elementary Lessons in Physiology*, or the smaller works by B. Moore and by Foster and Shore, during the first year is undoubtedly useful, yet for most men the practical study of Physiology begins in the first summer session. During this session he attends the classes in Practical Histology which are held three times a week, and for which he will need a microscope, certain mounting materials, and Schäfer's *Essentials of Histology*, which should be carefully studied.

During the first summer session and the first half of the second winter session the student should attend the lectures on Physiology (for times, *vide* table, p. 383), and also the tutorial classes which are held by the demonstrators. During this time he should read the subject in some text-book such as Starling's *Principles of Human*

Physiology, Halliburton's *Handbook of Physiology*, Stewart's *Manual of Physiology*, or Howell's *Text-book of Physiology*. While attending the practical classes held during the winter the student is advised to read *Practical Physiology* (published by Arnold).

Candidates for the M.B. of London or other Universities must in addition attend the class in advanced practical physiology held twice a week during the second winter session, and this class should also be attended by men working for the first F.R.C.S. examination.

Those desirous of obtaining distinction in the second M.B. examination should supplement the course of reading indicated above with original papers in the *Journal of Physiology*, with parts of Schäfer's *Text-book of Physiology*, *Recent Advances in Physiology and Bio-chemistry*, edited by L. Hill; *Further Advances in Physiology*, edited by L. Hill; and Leathes' *Problems in Animal Metabolism*. Revision classes are held by the demonstrators during the two months preceding the first F.R.C.S. and the M.B. examinations and should be attended by all candidates.

CHEMISTRY AND PHYSICS.

The student is often tempted to regard the study of Chemistry and Physics as one of very little use when once his preliminary examination is passed; but he will find in his study of the sciences of Physiology, Pharmacology and Pathology that a proper understanding of Chemistry and Physics is invaluable and essential. That this is so is now fully recognised in the curriculum of the London University which should be carefully studied by every London student.

The matriculated student will, in his first year, study Inorganic Chemistry, Physics, and General Biology, and at the end of this period, provided he has worked diligently in the laboratories, and attended the lectures and revision classes regularly, should have no difficulty in passing the First Examination for Medical Degrees. In his second year he will study Organic and Applied Chemistry, together with Anatomy and Physiology, and at the end of the second winter, provided, as before, that he has worked steadily from the commencement, should have little difficulty in passing the First Part of the Second Examination for Medical Degrees. Anatomy, Physiology, and Pharmacology are then taken as the Second Part of this Examination, at the close of the third winter, prior to commencing clinical work in the wards.

From the Conjoint and the Dental student only six months' work is required. but those entering without previous knowledge of Chemistry and Physics will find that time hardly sufficient, and are usually advised to take the full "year" of three terms, or nine months.

The importance of practical work cannot be too greatly emphasized, and lectures and books can but supplement work done in the laboratory. Guy's men have no excuse for neglecting laboratory work. The Chemical Laboratory, for example, is open every day from 9.30 a.m. to 5 p.m., and students are strongly urged to form early the habit of spending their spare hours, apart from those officially allotted, in one or other of the laboratories. Reading should be left for the evening. After a day in the laboratory, reading a good text-book will be found to give ample scope for thought, and rarely, indeed, be tedious. It is reading without practical experience that is so destructive of thought, and such reading is very properly stigmatised as "cram." "Cramming," or the memorising of words and phrases, without a knowledge of the corresponding realities, is one of the worst intellectual habits a student can acquire, and in the long run invariably leads to failure.

For the coming term, Chemistry Lectures start on Thursday, October 2nd, at 12.15 p.m. (Chemical Theatre, entrance opposite Laboratory, third floor); but before this students should go to the Chemical Laboratory (10 a.m.), to receive their locker keys and apparatus and commence practical work. Practical Organic and Applied Chemistry starts on Thursday, October 2nd, at 2 p.m., and the Lectures on Friday, October 3rd, at 11 a.m. *Physics Lectures* commence on Monday, October 6th, at 12 (Class Room IV., second floor).

PRACTICAL PHARMACY, MATERIA MEDICA, AND DISPENSING.

One of the many important things all medical students must know is how to write a prescription; it may even be necessary for the majority, when qualified, to know how to dispense the same, so that the student will do well not to neglect acquiring as much knowledge of this subject as he can.

The student is taught practically the methods of prescribing, he practises writing prescriptions for combinations of drugs with due regard to incompatibility, and he is taught how to dispense the prescriptions he has himself written.

The course covers the syllabus of the Practical Pharmacy of the Conjoint, the Intermediate M.B. Lond., and the Third M.B. Cantab.

During the year there may be three courses of three months each, should a sufficient number of students require instruction, which is given in the practical pharmacy class at the Dispensary by Mr. Finnemore, B.Sc. Lond., F.I.C., the Hospital Pharmacist.

MEDICAL WARDS.

The medical ward clerk should not read through a text book, but should become thoroughly acquainted with those diseases of which he finds examples in the beds which have been allotted to him. He should spend all his spare time in the medical words, observing and learning the physical signs of health and disease. If he is keen the house-physician will give him an opportunity of helping at "tappings" and venesections, and watching him examine an acute abdomen. He must have ready rough notes of the cases for the Medical Registrar, who goes round four times a week starting in the female

wards at 10.30, and he must write a full report for the Physician, and after the visit of the Physician, *the ward clerk should at once enter the remarks made by the Physician and his diagnosis.* The wards are always open to the clerks after 10 a.m., except from 1 to 1.30 p.m. The reports should be brief but thorough, and when in difficulties the ward clerk will always find the Registrar and Clinical Assistants ready to assist him. No ward clerk will know anything of medicine unless he attends regularly in the post-mortem room. The books usually read here are "Taylor" and "Osler," "Clinical Methods," by Hutchinson & Rainey, or "Medical Laboratory Methods," by French.

PATHOLOGY.

As soon as a student has passed his Second Conjoint or M.B. examination, he should begin his study of pathology. Without a sound knowledge of this science it will be impossible for him to obtain any real knowledge of medicine or surgery, and he can, therefore, never be too emphatically urged to attend the autopsies on everyone of his cases, and to spend as much time as possible in the post-mortem room. Autopsies are conducted every day of the week at 2 p.m. (Saturdays at noon), by Dr. Fawcett, Dr. French and Dr. Hertz. The microscopical examination of material removed by operation, is often the only means of arriving at a definite diagnosis, and it is therefore equally important that the student should obtain an adequate knowledge of microscopical appearances in disease.

Classes on microscopical pathology are held by Dr. Laidlaw and Dr. Eyre on Wednesday afternoons and Thursday mornings throughout the year. Bacteriology being taken in October to December and April to June, and morbid histology from January to March and July to September. Further the student should attend Dr. Hunt's classes on medical pathology, and Mr. Davies-Colley's on surgical pathology which are held three times a week.

In order to learn something of the principles which underlie pathology, the student should attend the lectures on general pathology. In May and October there are also informal classes adapted for the requirements of candidates for the first part of the Third M.B. Cantab., and the final M.B. of Oxford and London Universities.

The best elementary manuals are Green's "Pathology" and Adami and Macrae's "Text-book of Pathology"; Hewlett's "Pathology, General and Special" is good but hardly full enough. For general pathology read Adami's "General Pathology" and Lazarus-Barlow's "General or Experimental Pathology," and for morbid histology Grünbaum's "Essentials of Morbid Histology," or Woodhead's "Practical Pathology," of which the illustrations are very good. Many of the articles in Allbutt and Rolleston's "System of Medicine" should be consulted. For bacteriology Muir and Ritchie's "Manual of Bacteriology" is recommended.

BACTERIOLOGY.

Every Guy's man devotes at least three months to the practical study of Bacteriology. This compulsory course comes under the heading of Microscopical Pathology, and is held every Wednesday afternoon and Thursday morning from October to December, and again from April to June.

Bacteriology, although one of the youngest of the auxiliary sciences, has already made a most profound impression upon the theory and practice of both medicine and surgery, and by providing appropriate and specific treatment for bacterial infections has created the demand for exact as well as accurate diagnosis. Consequently, particular attention is devoted in this class to the technique of the various investigations undertaken in connection with the ward work. The student himself stains sputum, pus and morbid exudates by various methods to demonstrate the associated bacteria. He estimates the amount of specific agglutinins or opsonins contained in the serum of patients under treatment in the wards. In addition, he is instructed in the practical work of media-making, culture and staining methods, and is encouraged to repeat for himself during the intervals between successive classes any observations and experiments previously carried out, in order that he may be adequately prepared to take advantage of the advanced classes and lectures which are available during the fourth and fifth years of study, and to equip him for the performance in general practice of those more obvious methods of bacteriological diagnosis which the past generation of medical men are compelled to entrust to the pathological experts of their own or other hospitals, or, as so often happens, to the various commercial houses which make a speciality of clinical research and diagnosis. Demonstrations are also given upon the life-history of the various organisms pathogenic to the human race, and the changes such organisms undergo or produce when they gain entrance to the human tissues.

In order that the student may make the fullest possible use of his opportunities of correlating the clinical symptoms resulting from the infection of the patient's tissues by various pathogenic organisms, the class in bacteriology should be taken out as early as possible during the period of clinical study, and the work has so been planned that the whole of the six months devoted to microscopical pathology may run coincidently with the appointment of medical or surgical clinical clerk: and it should be emphasised that the clerk's absence from the wards during the hours the class is being held is not only sanctioned, but, indeed, is expected by his chiefs.

During February and March of each year a course of lectures is given dealing even more specially and technically with the applications of bacteriology to practical diagnosis and treatment, and in these the various remedial agents (serums and vaccines) which have been elaborated in the bacteriological laboratory for the treat-

ment of disease are fully discussed, together with the facts and theories relating to natural and acquired immunity upon which bacteriological therapy is based.

THE SURGICAL WARDS.

In the surgical wards there is a division of labour, and corresponding to this division, the appointments fall into two classes—clerking and dressing. The student's first introduction to clinical work is as clerk in the surgical wards, and it is not unlikely that he may, on his first entry, be a trifle discouraged. The reasons for this are obvious. Entirely ignorant of surgery and even of the terms in common use, he is at once required to write full accounts of the cases admitted to the wards. He will find, however, that, with the assistance available at his disposal, his difficulties will be found to be anything but insurmountable.

The most important point for a clerk to remember is that in after years cases and not book work will form his mainstay in practice, and that he cannot too soon get the clinical entity and results of treatment into his memory.

Let him bear in mind that to him is given by the hospital the task of keeping its records. These are bound and kept, and by his work thus perpetually in evidence a man is judged. Bad reports are a lasting disgrace; good reports a lasting honour. There is no better way of impressing the facts of a case on one's mind than is gained by the construction of a correctly detailed report, which, moreover, will be of value if the case has to be referred to at a future date. The importance of good careful work by the clerks cannot be over-estimated. In the nature of things it cannot be perfect, but it must be as perfect as he can make it. By his first work in the wards he will be judged, and he will find that it is very hard to live down a bad clerkship. At the same time that he bears in mind the difficulties and responsibilities of his post, he should remember that he is a junior, and that any assistance he can lend his seniors should be offered ungrudgingly, and in return for this he will undoubtedly meet with that consolation and help in his work which is so necessary.

It is essential that either the clerk should live within walking-home distance of the hospital, or else get a room for the take-in week. All really good casualty work is done at night, and the periods for seeing the actual application of Croft's and Bavarian splints and treatment of fractures is all too short as it is.

As soon as he is appointed, he should obtain from the Medical School office the "Notes on Surgical Case-taking" issued by it. A few days before taking over the work he will meet the surgical registrar to find out to whom he is appointed, and should then learn from his predecessor what he can about the cases he is to take charge of, so that the work may be continued as nearly as possible without a break. At the present time there is an entire change of clerks every three months, but in the way indicated above, the break in the work may be obviated to some extent. He should learn quickly to take accurate pulse and respiration rates, and test urine, for without any exception the temperature, pulse and respiration rates, and condition of the urine must be included in the notes of every case on admission. The surgical registrar sees every new case with the clerk on the morning after admission, when he expects a history of every case to be ready. This, if vague, is useless. All symptoms should be set down in exact order, with the dates of their appearance. The exactness in detail is of the highest importance, and is a measure of the care with which the clerk has done his work. He should have a note-book, and should put down in it everything about the case that he can obtain from the surgeon, house-surgeon, clinical assistant, and dresser. This should be copied into the report as soon as possible. We would impress upon each clerk the value of seeing everything done by the dressers or house-surgeons—the operations, putting up fractures, especially when done at night in take-in week, and this should apply to manipulations on every case under the surgeon, and not only to the cases which the individual clerk has to report—as much may be learnt in this way which otherwise can only later be gathered with much greater effort.

He should also attend the practical surgery classes of the surgical registrar, who gives four courses a year, each beginning on the appointment of the new surgical ward clerks, and especially designed for their instruction in all matters relating to that appointment, and also the course of practical pathology which is then in progress.

Lists of the duties appertaining to each appointment are supplied to the students, and these are to be carefully followed out. The hospital not only expects this, but insists on it. We have laid stress so far on the appointment of surgical ward clerk, as it is the first post that the student holds, and because he is so often quite unaware of the objects of the appointment.

The surgical wards are visited every day by the surgeons and assistant surgeons at 1.45. Notice of operations, which usually take place on Mondays, Tuesdays, Thursdays and Fridays, except for emergencies, is posted overnight in the colonnade by the House-Surgeon for the week. The surgeons are assisted at the operations by the dressers, and the particular clerk to the case should remain close by throughout the whole operation.

Although we believe there is no rule which prevents freshmen attending operations and clinical demonstrations, we would point out that such a course of action is useless to them, and is not encouraged by the authorities.

DAYS AND HOURS OF ATTENDANCE ON HOSPITAL PRACTICE.

Accidents and urgent cases of all kinds are admitted by the Maze Pond entrance at any time of the day or night.

THE WARDS.

Medical Wards.—Dr. Hale White (2), Mondays, Tuesdays and Thursdays. Dr. Pitt (2), Mondays, Tuesdays

and Fridays. Sir Cooper Perry (2.15), Mondays, Thursdays and Fridays. Dr. Shaw (2), Mondays, Tuesdays (10.30), Thursdays (10.30) and Fridays.

Surgical Wards.—Sir W. Arbuthnot Lane (2), Mondays, Tuesdays, Wednesdays, Thursdays and Fridays. Mr. Dunn (1.30), Mondays, Tuesdays, Wednesdays, Thursdays and Fridays. Sir Alfred Fripp (1.30), Tuesdays and Fridays. Mr. Steward (1.30), Mondays, Tuesdays, Thursdays and Fridays. Operations (1.30) daily.

Obstetric Ward.—Mr. Bellingham Smith (2), Tuesdays and Fridays. Mr. Chapple (2), Mondays, Wednesdays and Thursdays.

Ophthalmic.—Mr. Eason (2), Mondays and Thursdays. Mr. Ormond (2), Tuesdays and Fridays. Operations (2), Tuesdays and Thursdays.

THE OUT-PATIENT DEPARTMENT.

The days and hours of attendance in the Out-Patient Department of the hospital are as follows:—

Medical Cases.—Dr. Fawcett (1), Thursdays. Dr. Beddard (1), Wednesdays. Dr. French (1), Fridays. Dr. Hertz (1), Mondays. Dr. Cameron (1), Saturdays.

Surgical Cases.—Mr. Turner (1), Mondays. Mr. Fagge (1), Wednesdays. Mr. Rowlands (1), Thursdays. Mr. Hughes (1), Saturdays. Mr. Davies-Colley (1), Tuesdays and Fridays.

Obstetric.—Mr. Chapple (1), Mondays. Mr. Bellingham Smith (1), Thursdays.

Ophthalmic.—Mr. Eason (1), Tuesdays and Fridays. Mr. Ormond (1), Mondays and Thursdays.

Children's Diseases.—Dr. Cameron (1), Mondays; (9), Fridays.

Dental.—The Dental Staff (9) every week-day.

Throat and Ear.—Mr. Mollison (1), Tuesdays and Thursdays. Mr. Layton, Wednesdays and Fridays.

Skin.—Sir Cooper Perry (1), Tuesdays.

Electro-Therapeutic.—Dr. Hertz (1.30), Wednesdays and Thursdays.

Actino-Therapeutic.—Mr. Iredell (9.30), every week-day.

Orthopædic.—Mr. Trethowan (9), Tuesdays.

Nervous Diseases.—Dr. Hertz (9), Wednesdays.

Genito-Urinary.—Mr. Thompson (9), Wednesdays and Saturdays.

DENTAL SCHOOL.

The dental student is supplied at the Medical School Office with the Prospectus, Standing Orders, Notes on Probationary Work, List of Instruments, Calendar, and Clubs' Union Book.

These pamphlets should be carefully read in order that acquaintance may be made with the general arrangements of the school and the scope of the work upon which the student will become engaged.

Instruments having been purchased at a dental depôt, the student should satisfy himself that he has been supplied with all of those described in the hospital list.

Probationary work upon the phantom head will occupy the time for about two months. This operative course, conducted by the staff demonstrators, is very comprehensive. It includes most of the conservative operations that the student will subsequently be called upon to perform upon patients, namely, gold and other fillings, crowns, inlays, and the treatment of devitalized and septic teeth. These manipulations upon the dummy, when done in a thoroughly sound manner, form an excellent ground-work in operative dentistry.

Pupils in Dental Mechanics are received at the hospital, and a systematized and graded course of instruction is carried out by competent teachers.

The regulations of the Royal College of Surgeons of England require that students shall pass two professional examinations for the dental licence. At the first examination certificates must be produced, *inter alia*, of having been engaged in the practice of dental mechanics under a registered dental surgeon, or under the direction of the superintendent of the mechanical department of a recognised dental hospital, during a period of two years, and of having manufactured and adjusted six dentures and six crowns.

As this examination may be passed in the month of May, the work of the first winter session should be largely devoted to demonstrations, dental mechanics, and lectures

Students in difficulties about their work and needing advice are invited to consult the Dean, or any member of the Staff, who will be pleased to do what they can to promote the interests of students.

SPECIAL DEPARTMENTS.

There are at present ten special departments in the Hospital, namely, Throats and Ears, Eyes, Skins, Gynæcological, Nervous, Children, Actino-therapeutic, Electro-therapeutic, Orthopædic and Genito-urinary. In all these departments the latest methods of diagnosis and treatment are to be seen, and much valuable information may be gained by the student.

The Choice of a Microscope.

Immediately on entering the hospital our medical student finds himself faced with a problem of serious import, although he may at the moment fail to recognise it as such, viz., the Choice of a Microscope. The present-day study of medicine necessitates the use of the microscope from the most elementary stages until the moment when our fully-fledged medico leaves his *alma mater*, and, indeed, after that, if he is to put into practice the many aids to diagnosis which he has studied in the hospital laboratories. Occasionally it happens that he is already provided with an instrument of weird and wonderful design which served his forbears during the early days of microscopy, but such an instrument is useless at the present day. A comparatively simple microscope is adequate for the work carried out in the biology

class, where our student first comes to hand-grips with the microscope, but it must be borne in mind that later, when studying histology, and more particularly when he embarks upon the study of bacteriology, a really sound instrument and first-class lenses become absolutely essential.

We would impress upon the man who enters the hospital totally unfamiliar with microscopical work, the fact that the services of his teachers, whose experience in microscopical matters is extensive, and has been quickened by the observation of difficulties encountered by past generations of students, are always at his disposal. There should, therefore, be nothing to prevent him from purchasing at the very outset of his student's career, a microscope stand of thoroughly sound construction, and of such a pattern that the additions necessary to fit it, even for research work, can be added from time to time as the necessity arises, at comparatively small cost.

Although some twenty or thirty years ago Continental makers were unrivalled in the manufacture of microscopes, and still retain much of the reputation they then gained, yet at the present day the stands made by some of the British firms are undoubtedly superior in materials, workmanship, and attention to constructional details, and we would strongly urge the purchase of a stand of English manufacture; such for example as the Stand H (Edinburgh Students) made by Messrs. Watson & Sons, 313, High Holborn. This is of the tripod pattern, jointed, provided with a rack work, coarse adjustment, fine adjustment of the lever type, large stage, with square opening, fitted with mechanical movements, compound sub-stage (to which additional apparatus may be attached in the future), and a swinging double mirror, plane and concave, and costs about £10. The addition of a 1in. lens, a ⅓in. lens, and two eye-pieces, one magnifying two diameters, the other eight, at the cost of about another £3, provides the student with an instrument which will prove a faithful friend during the preliminary studies of biology and physiology. It will also serve him for his morbid histology, and when he enters the bacteriological class he will merely need to add an Abbé sub-stage condensor, costing from 15s to £1, a triple dust-proof nose-piece, £1, and a $\frac{1}{12}$in. oil immersion lens, which will cost him a further £5. Practically all the standard makers put a really good immersion oil lens upon the market at this figure, the best being those supplied by Watson & Sons, Crouch (Agents, Messrs. Maw, Son & Sons), and the Continental firms of Zeiss, Leitz, and Reichert.

In chosing a microscope it is not always true economy to obtain the entire equipment from any one firm; and it may be well at times to get a stand from one maker, the lens from another, the second lens from a third, and so on, for all lenses, etc., are made to standard screws, therefore accessories manufactured by different firms are interchangeable; and in this connection the expert knowledge of his teachers in the medical school is so valuable to the student.

Such a microscope as we have sketched out is the ideal from the point of view alike of the student and the teacher; but in some instances the initial cost may be greater than the student cares to incur, and if this is so, he will find that nearly all the reliable firms make less costly models, which will serve his purpose. For a student's microscope of proved reliability, Messrs. Watson & Sons' "Stand F" and "Fram" models are to be recommended; these instruments, with 1in. and ⅓in. objectives, eye-piece, and case cost £7 17s. and £6 5s. respectively.

Or again, the student may occasionally be able to acquire a good second-hand microscope comparatively cheaply, but such an instrument should never be purchased unless he can obtain it on approval, and submit it to expert opinion before completing the purchase, especially if the microscope is to be obtained from a pawnshop or second-hand dealer. A good plan, often productive of marvellous bargains, is to enquire of some first-class firm whether they have an instrument of their own make for disposal second-hand, as it sometimes happens that a microscopist disposes of a particular microscope in part-payment for a more expensive model, and in this case the purchaser of the second-hand instrument obtains the guarantee of the maker that the microscope is in good condition. Second-hand lenses may also be picked up occasionally; Messrs. Baker & Co., High Holborn, and Messrs. Millikin & Lawley in the Strand, usually have a good selection of second-hand lenses. Slide boxes or cabinets to contain finished slides can be obtained of any of the microscopical instrument makers, the nearest being Messrs. Stanley, whose place is close to London Bridge Station.

Instruments.

Both in the wards and in the dissecting-room and the physiological laboratory the student will find that he needs several instruments. In the wards he will want a stethoscope, dressing instruments, tape measure, blue pencil, and possibly such instruments as an ophthalmoscope, etc., and, in his previous work, a dissecting case is an absolute essential.

There are many instrument makers in London, the majority of whom make a point of catering for the new student.

The student would do well to give Messrs. Down a call and inspect their large and varied stock of dissecting cases, dressing cases, midwifery bags, etc. The firm supplies all apparatus necessary for work in the wards or in the laboratories, and all their material is of the best quality. The Holborn Surgical Instrument Company, Ltd., 26, Thavies Inn, Holborn Circus, E.C., have also a large stock of instruments, at comparatively cheap prices, while Messrs. Millikin and Lawley, Strand, London, W.C., have always on hand a large variety of new and second-hand instruments and bones.

At all these firms the student may obtain blood-counting apparatus, ophthalmoscopes, pocket spectroscopes and other desirable, if not absolutely indispensable, instruments. Messrs. Watson and Sons, of 313, High Holborn, and Mr. Baker, of 244, High Holborn, however, list special sets of blood-counting apparatus designed for students and clinical use, and in addition stock several sets of microscopical apparatus, including stains, etc. Messrs. Stanley, Station Approach, London Bridge, who are opticians to Guy's Hospital, have a large and extensive stock of microscopical apparatus, such as slides, specimen boxes, etc., and their shop is conveniently situated for those who cannot afford much time. Their articles are of excellent manufacture, and thoroughly satisfactory.

Books.

The student who wishes to obtain his books at once should not take the first he sees on any particular subject, but would be wise to consult his demonstrators first; the number of text-books is very large, and the choice is a difficult matter to the inexperienced. Roughly speaking, second-hand books are very seldom worth anyone's while to buy, chiefly because medical science is progressing so rapidly that new editions are constantly being published.

The number of publishers of books for medical students is great. Messrs. Churchill published Taylor, Jacobson, Goodhart, Fagge, and many other well-known works. Messrs. Macmillan publish Allbutt, Foster, and a great number of first-year books; Messrs. Longmans, Green & Co. publish the famous Gray's Anatomy. Mr. H. K. Lewis, 136, Gower Street, publishes a number of medical books, and has also a medical circulating library which is valuable to students who wish to see all the latest books. Mr. Murray also publishes many well-known medical books, as also do Smith, Elder & Co.; Philip & Son; Cassell & Co.; and Nisbet & Co.

As we have mentioned, it is rarely that second-hand books will be required, but there are cases in which they are valuable. Mr. Chas. Sawyer, 29–31, New Oxford Street, W.C., has a long list of last editions at very moderate prices, and there are other second-hand booksellers.

All books can be obtained from Mr. H. H. Grattan, in Borough High Street, who is the "official bookseller" to the hospital. Many well-known books he can supply over the counter; any others desired he will have in an hour or two.

Osteology.

The question of the purchase of bones is always an important one. Millikin & Lawley, in the Strand, make a speciality of supplying the medical student with this part of his equipment.

Guy's Hospital Clubs' Union

THE FORMATION OF THE CLUBS' UNION, by the amalgamation of the various constituent institutions, took place in the summer of 1891. The objects of the amalgamation are to further the interests of the clubs and societies existing at the hospital by their mutual support, and to simplify the collection of subscriptions. By the payment of an annual subscription (see Clubs' Union Year Book, p. 13) to the Clubs' Union, any student of the hospital can obtain the privilege of membership of the constituent institutions.

THE GROUND OF THE CLUBS' UNION, which is under the control of the council, is situated close to Honor Oak Park Station, on the London, Brighton and South Coast Railway, and to the Crofton Park Station on the South Eastern and Chatham Railway. It is nine acres in extent, and is the headquarters of the Guy's Football, Cricket, Athletic and Lawn Tennis Clubs. Return tickets at single fare are issued by the Brighton Railway Company. Under such restrictions as are found necessary by the committees of the several clubs, and are approved by the council of the Clubs' Union, every member of the Union has opportunities of practising and taking part in matches, and in the various sports and games. There is a large pavilion upon the ground, with dressing and lavatory accommodation. Refreshments can be obtained by members of the Union according to the tariff of the Students' Club.

CONSTITUENT INSTITUTIONS.

THE CRICKET CLUB.—President: C. H. Fagge, Esq., M.S., F.R.C.S.; Captain: A. H. Harkness; Hon. Sec. and Treasurer: B. F. Sampson.

Matches are played throughout the summer session, fixtures being made for two XI.'s. There are both a Senior and Junior Inter-Hospital Cup. Guy's has won the Senior Cup seventeen times since its inauguration in 1882. The Junior Cup has been in existence seven seasons. Guy's has won it five times.

Practice matches are held early in May, and all freshmen should put their names on the list. Blues are given to the members of the Cup team, and Half-Blues to some members of the 2nd XI.

The Annual General Meeting will be held in March.

THE FOOTBALL CLUBS.—President: John Fawcett, Esq., M.D. Rugby—Captain: C. S. L. Roberts; Hon. Sec.: H. Millett; Captain 2nd XV.: K. Day-Lewis; Captain 3rd XV.: E. N. Glover; Captain 4th XV.: G. B. Dowling; and a committee of five, one representing each year. Association—Captain 1st XI.: A. C. M. Coxon; Hon. Sec.: L. Gill; Captain 2nd XI.: J. L. Bensted; and a committee of five, one representing each year.

The Rugby Football Club has now been in existence for over sixty years. Very little is known of its early history. Among the many well-known players who at one time or another have played for Guy's may be mentioned the following International footballers:—A. W. Pearson, W. W. Pinching, A. H. Jackson, L. Stokes (Captain 1877–8), A. S. Taylor, W. G. Mitchell, A. Allport, H. W. Dudgeon, A. Alcock, H. Lee, H. Archer, G. R. Hind (England); H. H. Jordan, E. Morgan, J. P. Jones (Wales); R. Evans (Scotland); F. O. Stokes (Ireland).

The Inter-Hospital Challenge Cup was instituted in 1874, and Guy's had the honour of being the first holders. Since then Guy's has held the Cup sixteen times, St. Thomas's ten times, London five times, St. George's three times, St. Bartholomew's twice, and Middlesex and St. Mary's once each. In 1891, Guy's, Middlesex, and St. Thomas's were left in, the ties not being played out.

Last season Guy's retained the Cup for the fifth year in succession by beating London in the final by 3 points to nil. In club footer we won 10, lost 10, and drew 2.

The 2nd XV. won the 2nd Cup Tie for the sixth time in succession, and with the 3rd XV. had a good season.

A 4th XV. is now established, and a good fixture card has been arranged. Trial games will be played in the first week of October. For the benefit of freshmen in particular, we may state that lists will be put up in the Smoke-room, on which intending players should write their names as soon as possible. The officers of the clubs will at all times be very glad to give any information in their power.

The Association Football Club was founded in 1882, and a high measure of success has rewarded its efforts from its earliest days. Four years later (1886) the Inter-Hospital Challenge Cup (Senior) came into existence, and of the twenty-five occasions it has been competed for, Guy's has "been on top" no fewer than twelve times, St. Bart.'s being our nearest opponents with five wins. In its very palmiest days, Guy's also won the Surrey Senior Cup, viz., in 1887 and 1889. Last season we were beaten in the semi-final of the Hospital Cup by St. Thomas's by 6 goals to 3. We, however, beat London in the 1st round by 2 goals to 0. Our 2nd XI. was beaten by St. Thomas's in the final by 3 goals to 1.

Early in October trial games will be arranged to take place at Honor Oak, more especially for the benefit of "freshmen," and it is to be hoped that no freshman interested in Hospital "Soccer" will hesitate, *for any reason whatsoever*, to avail himself of this golden opportunity of proving his worth on the field, for it is largely on the result of these games that his subsequent inclusion in the team depends. Notices of such trial games will be posted in the Smoking-room of the College. The club has entered for both the Surrey Senior and Junior Cups.

THE LAWN TENNIS CLUB.—President: Sir W. Arbuthnot Lane, Bart., M.S.; Vice-President: J. Fawcett, Esq., M.D.; Captain: H. Sharpe; Hon. Sec., L. A. Graham, and a committee of six students.

The Lawn Tennis Club was founded in 1888. Two teams are run during the season, which starts on May 1st and finishes at the end of July. There are two Inter-Hospital Cups. The Senior Inter-Hospital Cup was won again this year, and thus remains in our possession for the sixth year in succession. A trial game is held early in the season, and tournament singles are played for the Arbuthnot Lane Cup during the season.

THE ATHLETIC CLUB.—President: J. Fawcett, Esq., M.D., F.R.C.P. Hon. Secs. and Treasurers: H. Mather and J. R. Barrow-Clough, and a committee of eleven. The annual summer meeting is held in June, when the Lucas Challenge Cup is competed for, at the Clubs' Union ground. The team which represents Guy's in the Inter-Hospital Sports is chosen on the results of our sports. Blues and Half-Blues are awarded at the discretion of the committee. There is also a contest between the United Hospitals and Dublin University when possible.

In connection with the Athletic Club there is a Cross-Country Club, which has runs every Saturday, and races with the leading London clubs, and the Universities of Oxford, Cambridge and Dublin. Half-Blues are awarded in the Inter-Hospital Cross-Country race. Full particulars and notices of all club matters are to be found on the colonnade notice-board and in the smoke-room.

THE GOLFING SOCIETY.—President: G. Newton Pitt, M.D. Vice-Presidents; H. C. Cameron, M.D., H. L. Eason, M.D., M.S., C. H. Fagge, M.S., F.R.C.S., J. Fawcett, M.D., A. W. Ormond, F.R.C.S., F. J. Steward, M.S., F.R.C.S., R. Davies-Colley, M.C., F.R.C.S., and E. C. Hughes, M.C., F.R.C.S. Committee: R. Creasy, O. Morgan, G. Noott, F. A. Knott, F. G. L. Scott, R. A. Fawcus. Hon. Secretary and Treasurer: R. Curle.

This society was formed in May, 1908, for the purpose of promoting Inter-Hospital Golf, and also to provide local interest by means of competitions, matches, etc. The society is affiliated to the Clubs' Union, and therefore all members of the Union are members of the society. Matches are arranged with other hospitals and clubs. Competitions, open to staff and students, are held three or four times a year, due notice of which is posted in Colonnade and printed in GAZETTE.

An arrangement has been made by which members of the above society may play on five days in the week—viz., Monday to Friday—at the Ilford Golf Club, on payment of an annual subscription of £1 1s., without entrance fee. Such members may play on Saturdays, Sundays and Bank Holidays at the rate of 2s. 6d. a day.

We are indebted to the Committee of the West Essex Golf Club for the following arrangements:—Members of the Guy's Hospital Golfing Society may become five-day members of the West Essex Golf Club on payment of an annual subscription of two guineas, without entrance fee. Such members may play on Saturdays and Sundays on payment of a daily green fee of 2s. 6d. Members of the Society may play at West Essex any day, except Sunday, at a green fee of 2s. 6d. a day, On Sundays the green fee is 5s., unless accompanied by a member of the West Essex Club, when it remains at 2s. 6d. An arrangement has also been made with The Foxgrove Club, Beckenham, by which members of the society may play on any day, by payment of a green fee of 2s. 6d.

HOCKEY CLUB.—President: F. J. Steward, Esq., M.S., F.R.C.S. Vice-Presidents: A. W. Ormond, Esq., F.R.C.S., and C. H. Fagge, Esq., M.S., F.R.C.S. Captain: L. A. Graham; Hon. Secs. and Treasurers: H. N. Purdom and J. H. Parry.

For the seventh time in succession, Guy's were again successful in winning the Inter-hospital Hockey Tournament, beating St. Bart.'s Hospital by 5 goals to 1 in the final.

The General Meeting has been provisionally arranged for October 4th, and there will be two trial games early in that month. It is earnestly hoped that all freshmen and others who desire to play will put their names down on the list in the Smoking Room.

All communications should be addressed to H. N. Purdom and J. H. Parry.

THE PUPILS' PHYSICAL SOCIETY.—Hon. President: Sir James Goodhart, Bart., M.D., LL.D. Hon. Vice-Presidents: Frederick Taylor, M.D.; Sir Geo. H. Savage, M.D.; C. J. Symonds, M.S. Hon. Secretaries: G. T. Mullally, M.B., B.S.; T. B. Heaton, M.B., B.C.

This flourishing society was founded in 1830, on the plan of the old Physical Society, which existed during the latter part of the eighteenth century at Guy's Hospital.

At the Pupils' Physical Society, which meets each fortnight on alternate Wednesday and Saturday evenings, a paper on some subject, not necessarily of medical interest, may be read by any member, to be followed by a discussion. "Clinical" and "Pathological" Evenings are devoted to the exhibition and discussion of interesting cases or specimens which may be shown by any member. Members are reminded that in connection with the society the following prizes are offered for competition: The Treasurer's Prize of £5 is given annually; the subject of the Essay for this year is "Surgical Shock." The society offers a prize of £10 for the best paper read during the session; a prize of £5 to the member who distinguishes himself most in the discussions; and a prize of £5 to the member who exhibits the best specimens of scientific interest during the session.

THE DEBATING SOCIETY.—President: L. E. Shaw, M.D. Vice-Presidents: J. Fawcett, M.D., E. I. Spriggs, M.D., A. W. Ormond, F.R.C.S., H. C. Mann, M.D., M.R.C.P., A. R. Thompson, F.R.C.S., T. B. Layton, F.R.C.S. Hon. Secretary: G. Neely. A committee of the Secretary and six students.

Members of the Clubs' Union, junior as well as senior, are specially invited, in their own interests, to attend as many as possible of the meetings of this society.

The endeavour has been made to choose subjects within the scope of the limited interests of the medical student, and it is hoped that all will try to be present who are not too blasé to listen to the views of others, or too slack to give others the benefit of their own.

The list of debates will be published in the GAZETTE; anyone willing to take part is particularly requested to communicate with the Secretary.

THE DENTAL SOCIETY.—President: F. N. Doubleday, Esq. Hon. Secretary and Treasurer: H. Millett.

The object of this Society, which was founded in 1894, is the promotion of interest in Dental subjects, and the discussion of Dental topics. Papers are read before the Society each month, and a prize (value £5) is awarded for the best paper read before the Society during the session. Casual communications are invited at all meetings, and a prize (value £1) is awarded at the end of the session for the best set produced.

One meeting during the session is set apart for the examination and discussion of cases of special interest, the patients being brought up for examination.

The meetings are held every month during the winter session in Class Room No. 2 in the Medical School Buildings. The meetings take place at 4 p.m. on the second Friday in the month, and tea is served before the meetings for members attending the meetings. New men are strongly urged to attend and take part in these meetings, which, in the past, have proved instructive as well as interesting.

THE GUY'S HOSPITAL REPORTS.—Edited by F. J. Steward, M.S., and Herbert French, M.A., M.D.

The Reports are published annually, and each subscriber to the Clubs' Union is entitled to a copy, which he may obtain in the Wills Library from the Librarian. Each volume contains papers by members of the Staff of the Hospital and Medical School upon original work done in the Hospital during the preceding year; it also contains a list of the gentlemen who have been educated at Guy's Hospital, with the appointments they have held during the year, the examinations they have passed, and the prizes and honours they have won. The first volume appeared in 1836; copies of the earlier volumes can be obtained from the Editors. The value of this annual publication is obvious, and every Guy's man is proud of the original papers of its Staff, from those of Addison, Bright, and Hodgkin, to those of the present day.

THE STUDENTS' CLUB.—Officers till 1914 (March). President: W. Hale White, M.D.; Treasurer: John Fawcett, M.D.; Hon. Secretary: T. B. Layton, M.S.; Hon. Assistant Secretary: H. Gardiner, M.B.; and a committee of eight.

The above named manage the affairs of the Club, a full account of which will be found in the Clubs' Union Blue Book.

GUY'S HOSPITAL CHORAL SOCIETY.—This Society will begin rehearsals for the Winter Season early in October. The practices are held every Friday, at 5 and at 8 p.m., in whatsoever room shall be deemed convenient for the occasion. Notices are posted on the screens opposite Astley Cooper door, in the Dissecting Room, and in the Students' Cloak Room, Medical School.

Since the success, and, indeed, the very existence of the Society depends entirely upon the keenness and enthusiasm of those students who are musically disposed, it is hoped that all freshmen who have voices, or other musical talent, will announce the fact by their presence at the rehearsals.

All particulars may be obtained from the secretaries, H. Q. F. Thompson and J. J. Sterling-Hill.

BOXING, FENCING AND GYMNASIUM CLUB (The Pavy Gymnasium). President: H. L. Eason, Esq., M.S.; Treasurer: W. M. Mollison, Esq., M.C. Committee: Messrs. G. T. Mullally, Faskin, Portway, Maelzer, E. A. Leviseur, Coe, and Whitten. Hon. Secretary: F. W. Stiven.

The Pavy Gymnasium, which was built and endowed by the generosity of the late Dr. Pavy, is situated in the Quadrangle of the College, and is open to members of the Clubs' Union at all times.

Throughout the winter session, classes conducted by thoroughly competent instructors are held weekly in boxing, fencing and gymnastics. An excellent wrestling mat has recently been acquired by the club, and if there is sufficient support an instructor in wrestling may be engaged. At the end of the winter session an Annual Assault-at-Arms is held, and a team selected to compete in the Inter-Hospital Boxing, etc.

All men who are interested in this club are earnestly requested either to make themselves known to the Secretary or to one of the Committee, or to turn up to the Classes in the Gymnasium at the advertised times.

G. T. M.

GUY'S HOSPITAL GAZETTE.

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Passim.

THE Opening Dinner on October 1st, of which an account will be found in another part of this issue, has come and gone, and we have all put our hands to the plough again, or, as some would have it, our noses to the grindstone. We are, perhaps, already in a position to take stock of ourselves and see what changes the New Academic Year has wrought among us.

And, firstly of course, what of the New Men? As will be seen from the report of the Dean's speech on October 1st the entry into the Dental School has surpassed all expectations and constitutes, we understand, a record. The entry into the Medical School, although not by any means a record, continues satisfactory and well up to the average of recent years.

WHILST we are thinking of this subject we inevitably tend to draw comparisons between the entries of the last few years and those of ten or fifteen years ago. Of course the striking feature in this comparison is the great diminution in the numbers of those entering the profession which has gradually taken place. We are talking not of Guy's alone, nor yet of London Schools alone, but of all British Schools of Medicine. Every Medical School in the Kingdom reports the same gradual diminution in the number of men taking up medicine, and the figures of the General Medical Council bear out their statements. In this decrease Guy's have of course shared, but it has not been so deeply involved as many, or indeed most of its contemporaries. So that we have no reason to repine on that score.

The factors that make for this progressive decline are many, and all of them are not clearly understood. No doubt the over-crowding of the profession which undoubtedly occurred some years ago, with the consequent increase in the difficulty of making a sufficient livelihood, has had its effect in inducing doctors to put their sons into some other calling than medicine. The increasing length and complexity of the curriculum have also, we believe, had a potent influence in the same direction, both upon the profession and upon the lay public. The great increase in the number, and the opportunities of the other professions, has also reacted adversely upon the entry into the Medical Schools.

WHAT will be the effect of this decrease upon the present and future prospects of the profession? We already begin to see some phenomena which are in part, at least, the direct result of it. We recently, in these columns, drew attention to the great scarcity of recently qualified men, with a consequent dearth of men available for resident appointments at hospitals, and as *locum tenens*. This scarcity which has had as one result a general increase in the scale of salaries paid to house-officers generally throughout the country, has also affected the Services—Army, Navy, and I.M.S.—and has been largely responsible for the improvements

which have been effected of late years in these branches, in order to make them more attractive.

The scarcity of recently qualified men has been intensified by a change which has gradually occurred in the field open to the activities of medical men. We refer to the increasing number of posts in the State and Municipal Services which are available to doctors, and which offer them a sure and steady, if not munificent, income, free from the chief worries of private practice. These two factors—the ever widening field and the decreasing numbers—are gradually making their influence felt, and that influence is, of course, all for the benefit of the recently qualified man. There has probably never been before a period at which his services were at such a premium. One supposes that this shortage of men will continue for some years until it is generally recognized again that a man may keep his self-respect and make a comfortable livelihood as a doctor. Then probably there will occur a "boom" and again a period of overcrowding,

The results of the Scholarship examinations will be found elsewhere in this issue, but we would take this opportunity of congratulating the successful men and heartily welcoming the new comers among them. We note especially in the list F. C. Miller, from St. Paul's—we have had many brilliant men from St. Paul's in the past, and among recent recruits is L. S. Debenham, a Medical and Dental Student who won the Science Scholarship in 1912. It is a curious thing that the competition for the Scholarships is in some years rather restricted, appearing almost as though many of the new students were unaware of their existence. We cannot think of any other plausible reason. The day has not yet arrived—and we hope it never will—when the medical student can afford to sniff at two or three years' free tuition.

Not only has the entry in the Dental School increased in numbers of late years, but in addition an increasing number of dental men are taking the medical qualification also. Most of them seek the Conjoint Diploma, but we know of at least one man who is also taking the London course. More than one dental man has in addition, during recent years, taken the Primary Examination for the Fellowship. It augurs well for the future of the profession of dentistry to find so many men willing to give the extra time and work in order to gain a fuller knowledge of their subject.

In Hospital itself two new departments came into being on October 1st—the department of Microscopical Pathology, under the ægis of Dr. G. W. Nicholson, and that of Chemical Pathology, of which Mr. J. H. Ryffel has charge. From that date also we have had four Medical Registrars. In the Medical School the new Lecturer upon Pharmacology, Dr. A. J. Clark, has started work, as has also Dr. Boycott's successor in the Pathological Department, Dr. Laidlaw.

In the Dental School the most striking change during the past year has been the appointment of Mr. F. B. Bull as Resident Dental Officer. This change, we hear, has added enormously to the efficiency of the Dental School upon its administrative side.

Having taken a bird's-eye view of recent events for the benefit of our readers, we look forward into the future, thinking chiefly of ourselves. We see long and interesting fixture lists of this club or that society, and we sigh wearily as we picture ourselves urging recalcitrant secretaries to let us have reports in by Tuesday night at the latest. And so, of course, we make an appeal in advance to *all* the secretaries and correspondents of *all* the clubs and societies to let us have full reports of their respective activities. We would like to receive them on the Monday preceding publication, and must have them by the Tuesday night at the latest.

The dinner to Dr. Pitt on the occasion of his retirement, of which we spoke in our last issue, will take place on Monday, October 13th, at

7.30 p.m., at the Trocadero. Tickets, price 5s. 6d. each, may be obtained from Mr. T. I. Bennett, Dr. Pitt's H.-P. We regret that we are compelled, owing to the shortness of the time, to hold over till our next number the promised portrait of Dr. Pitt.

We would remind men in the wards that, although the Physical Society did not hold its usual Conversazione this year, it is by no means moribund, and promises to have an unusually successful session this winter. The Programme is a long one, and contains several interesting items, notably a Discussion on the Treatment of Syphilis, which is to be opened by Major Pollock, R.A.M.C., and is peculiarly appropriate this year when so much attention has been focussed on the question of venereal disease. An address by Dr. Wheeler, of the London Homœopathic Hospital, on "Homœopathy," also promises to be of unusual interest.

The first meeting of the Society will be held this (Saturday) evening, at 8 p.m. The meeting is a Clinical one, and cases will first be shown in the new Clinical Theatre in the Surgical Building, and an adjournment then made to the Library for discussion. It is to be hoped that there will be a big turn up of men in the wards.

In the *Hospital* for October 4th, there is an article, entitled "Blind-Alley Hospital Employment: The Case of the Laboratory Boy," which points out what a pity it is that so many boys employed in laboratory work find that after a few years they have no further prospect of improving their positions and are compelled to leave and seek other work. And, further, that their work as laboratory boys, although it may be highly skilled, is of too special a nature to be of any value to them outside a scientific institution. The writer, after pointing out how wrong it is that this condition of affairs should exist, goes on to suggest that an effort should be made to find posts elsewhere in the hospitals for these boys when they outgrow their laboratory usefulness. Being in full accord with the writer, we immediately inquired whether any attempt to tackle this problem had been made at Guy's. We were agreeably surprised to find that the matter had been fully considered some years ago, and that for over a year a scheme for avoiding the evil complained of had been in working. Briefly the scheme is as follows:—When a laboratory boy approaches an age at which he should begin to earn more money than the laboratory is prepared to pay him, he is advised, if necessary, that there is no prospect of further advancement in his present employment, and is offered an apprenticeship in one of the shops of the Works Department. His parents are expected to find a part of the premium and the authorities find the remainder. The scheme has so far been very successful, and several boys have availed themselves of the opportunity thus provided. It is with no small pleasure that we have unearthed an example showing that even a scientific body is capable of moving abreast of, if not ahead of, the most modern developments of social ethics.

We have received a notice from the University of London Athletic Union, announcing that two Dances will be held at the University, South Kensington, on Friday, November 28th, 1913, and Friday, February 20th, 1914. The tickets will be 4/6 each, and men keen on dancing are asked to keep these dates open. We are promised further information at a later date.

Change of Address.

Harold Chapple, M.C., from 26, St. Thomas's Street, S.E., to 18, Devonshire Street, Portland Place. W. *Telephone No.* Mayfair 3509.

Brooke Churchill, Captain R.A.M.C., to 20, Matheson Road, West Kensington.

C. H. Marshall, M.R.C.S., L.R.C.P., Medical Officer, Uganda Protectorate, has returned to duty after leave of absence.

W. T. Chaning-Pearce, M.B., B.C., from Montague House, Ramsgate, to The Old College, Petersfield, Hants.

Edward G. Reeve, M.R.C.S., L.R.C.P., to 1, Cranley Gardens, Queen's Gate, S.W. Telephone, Western 6618.

Alexander Sandison, M.B., B.C., B.Sc., from 29, St. Peter's Road, Croydon, to "Wildfell," Kingsdown Avenue, South Croydon.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Opening of the School Year, 1913-14.

Dinner in the College Dining Hall.

The wisdom of the School authorities in reverting to the old custom of having a dinner in the College to mark the opening of a new school year was seen to be amply justified on the evening of October 1st last. The dinner was an immense success from start to finish, and never have we seen the Dining Hall so packed—we understand that over 130 people sat down—in fact, personally we could have wished that there was not quite so large a gathering. The diners formed a group thoroughly representative of Guy's School and Hospital. The Governors were represented by the President of the Hospital, Mr. Cosmo Bonsor, who occupied the chair at dinner; the Consulting Staff by Sir George Savage and Messrs. Clement Lucas and Charters J. Symonds; the active Staff by the Senior Physician, Dr. Hale-White, the Senior Surgeon, Sir Arbuthnot Lane, by Dr. Newton Pitt (so soon, alas! to be on the Consulting Staff) and several other of our physicians and surgeons, and the Dental Staff, by, among others, Messrs. Wynne Rouw, Montagu Hopson, and J. Lewin Payne.

There was a large group of old Guy's men, and we also noticed several unfamiliar faces among the younger men, whom we understand were freshmen. As we approached the last course, the Chairman proposed the usual loyal toasts of "His Majesty the King and the Queen and the Royal Family," and gave us leave to smoke.

After a song by Mr. H. Q. F. Thompson, the Chairman then called upon the Dean, Dr. H. C. Cameron, to present his Annual Report of the Medical and Dental Schools. In doing so, the Dean referred to the extraordinary activity which had been displayed in every Department of the Medical School throughout the year. Not only had the new Pathological Department been brought into smooth working order, but the opening of the session was marked by the simultaneous birth of three new Departments—those of Pharmacology, Morbid Histology, and Chemical Pathology, under the direction of Drs. A. J. Clark, G. W. Nicholson, and J. H. Ryffel respectively—Departments which were adequately housed, equipped, and staffed. With regard to the future of the Medical School, while it would be folly to deny that the present time was a critical one for all Medical Schools in London, he was able to say this much: that while not a few other Schools had sensibly declined, the Medical School of Guy's Hospital had at least held its own, and even increased its numbers during the past year; and that so far as the financial position of the School was concerned, thanks to the generosity of the Governors and other friends, no single scheme for improvement, which had won general approval, had had to be withdrawn or even postponed for lack of funds. They had set themselves to develop and perfect so far as possible the peculiar system of clinical training which was the pride of all the Schools of Medicine in London, and he thought that the report of the past year's work showed that in this they had been eminently successful. Whatever changes the future had in store for them they had at least been successful in the work which immediately lay to their hand.

With regard to the Dental School, he said that the enormous outlay which the Dental School had undertaken on account of the recent extension of the Department had been justified to the full by the absolutely astounding influx of students which he had been witnessing during the last few days. The Dental Staff had been occupied during the past year in setting their house in order and in systematising and re-organising the work in the largely increased accommodation for students and patients which was now at their disposal; especially, the whole of the teaching had been systematised and amplified, with the satisfactory result that the remarkably high percentage of successes by Guy's students at recent examinations had been the subject of general comment among those interested in dental education. There could be little doubt that the successful future of the Dental School was secured for many years to come.

Mr. Cosmo Bonsor then proposed "The Medical and Dental Schools." He first expressed the regret of all of us on the retirement of Dr. Newton Pitt from the Active Staff, and conveyed to Dr. Pitt the good wishes of all Guy's men, past and present. He voiced the general desire that Dr. Pitt will not cease to grace with his presence in the future numerous hospital functions. He then spoke of the recent extensions of the Schools and Hospital, and emphasized the fact that for teaching and research their equipment was complete and second to none. He told us of the great personal efforts that the Staff had made to provide the money for ever increasing needs of the School, and said that, during all the years in which he had presided over the Meetings of the School, the one thing which had impressed him most was the absolute determination of the Governors and Staff alike that no reason whatever should be allowed to stand in the way of securing efficiency in teaching and opportunity for investigation and research, and that no financial sacrifice to attain these ends could be too great.

Dr. Hale White, who replied on behalf of the Schools said that this year was for various reasons one of the most auspicious in which to take up medicine,

and that Guy's was, of course, the best place in which to take it up. He spoke of the enormous debt of gratitude which the School owed to the long line of Treasurers. In further development of his statement he gave us a short sketch of its history from the time of the United Hospitals, through its rise under "King" Harrison to a period of depression which had seized the Hospital and School alike when Mr. Cosmo Bonsor first came upon the scene as Treasurer. He pointed out that the renascence which had placed the School in its present unrivalled position coincided with and was due to the influence of our present President upon the hospital. The work which Mr. Bonsor had initiated was being admirably carried on by his successor in the office of Treasurer, Viscount Goschen, who, to everyone's regret, was unable to be present that evening.

At the conclusion of the speeches the Dean read out the names of those who had obtained prizes and scholarships during the past year, and the Chairman presented the Treasurer's Gold Medal in Clinical Medicine to Mr. C. H. Gould, and the Golding-Bird Medal in Bacteriology to Mr. A. J. E. Smith. During the evening Messrs. H. Q. F. Thompson and T. W Sheldon delighted us all by singing several songs. Mr. H. T. Depree accompanied them on the piano.

As we all stood up to leave some thoughtful man called for three cheers for Mr. Cosmo Bonsor, and it was delightful to see how heartily everyone present, staff and students alike, joined in the response.

The Resurrectionists.

V.

"Quoth Jack, 'Your Honour's very kind:
And now I call the thing to mind,
This parish very strict I find;
But in the next 'un
There lives a very well-inclin'd
Old kind of sexton.'"

Jack Hall, Hood.

Reference has already been made to the two authorities to whom we are chiefly indebted for the story of the body-snatchers, and it here becomes necessary to explain how Bransby Blake Cooper and John Flint South were afforded the opportunities for acquiring their special knowledge.

At the beginning of the nineteenth century, when this traffic first became of serious importance, the Borough Hospitals had been associated for teaching purposes for over thirty years, the instruction in medical subjects being imparted exclusively at Guy's, whilst the courses in surgery, anatomy, and dissecting were conducted at the sister hospital. Lectures on medicine and the allied subjects were delivered solely by Guy's men, but the teaching of anatomy was always undertaken by surgeons elected impartially from both institutions.

Under this arrangement the elder Cline and Astley Cooper were lecturing together in 1800. Cline resigned in favour of his son, who died in 1820, and was succeeded in the joint lectureship by his cousin, Joseph Henry Green. The demonstratorship of anatomy then vacated by Green, was held for a while by Charles Aston Key, and when he resigned in 1823 this post was shared between Sir Astley's nephew, Bransby Cooper, and a former apprentice of the younger Cline's, named J. F. South. When, in consequence of dissensions between the heads of the two hospitals, Guy's established an independent school in 1825, the anatomical department was presided over by Green and South at St. Thomas's and by Key and Bransby Cooper at Guy's.

The two men were thus engaged at the Borough Schools during the years in which the traffic was at its height, and as both of them had frequent dealings with the leaders of the resurrectionists we are fortunate in possessing their descriptions of the same characters from different angles of vision; and, although South's earlier experiences as prosector and, afterwards, assistant demonstrator of anatomy gave him the longer range of service in the dissecting-room, Bransby had the advantage of acquiring much information on the subject by his close association with his uncle.

Bransby discreetly tells us of a couple of unpleasant adventures which J. F. South experienced in his early dissecting-room days. At one time the leader of the resurrectionists, a cheerful ruffian named Murphy, would present himself at the beginning of a new session to enter upon the preliminary negotiations with the superintendent of the dissecting-room for a regular supply of bodies during the winter months, and a dialogue of this sort would ensue:—

"Well, Mr. ——, what does Sir —— mean to stand this season?" "Oh! I don't know, Murphy, whatever's fair. What will you take this morning?" "Nothing, I thank you, Mr. ——; but I don't mean to work this season without I get ten guineas a subject." "Oh, indeed! Well, we don't mean to give more than eight!" "Then you may go and tell Sir —— that he may raise his own subjects; for not one will he get from us."

And the gang would withhold supplies for three weeks or a month. At the end of that time, after the inferior practitioners engaged to take their place had failed to maintain an adequate supply, owing to their lack of skill and because the regular gang had conveyed information respecting their movements to the police, Murphy would again put in an appearance.

"Come, you can't get on without us; give us fifty pounds down and nine guineas a body, and we will

work for your school and no other." And although the school authorities soon learned by experience to put no faith in the promise of exclusive service, the bargain was generally agreed to. On one occasion Mr. Abernethy, of Bart.'s, paid Murphy a bonus of £50 in earnest of a regular supply, but in the end neither received the money back nor was supplied with a single body.

The preliminary gratuity, or "entrance money," ostensibly provided for feeing the watchmen and sextons, came to be regarded as an established perquisite of the leader, who refused to share it with his associates; and it was afterwards supplemented by a further extortion known as "finishing money," at the end of the term; and Murphy found little difficulty in obtaining these fees from four or five schools simultaneously.

With a view to avoiding such a preliminary exaction of twenty guineas, one of the lecturers at St. Thomas's was simple enough to propose to Murphy himself that the necessary payment should be made directly to the watchman of a churchyard near Holborn by one of the hospital officials. Murphy, although objecting that the new arrangement might prove dangerous, consented to bring about the meeting, but deferred the expedition until after dusk on the plea that it was desirable to avoid recognition. Meanwhile, as may be imagined, he hastened to see the gravedigger and arranged for the pantomime that followed. In due course Mr. South, at that time one of the demonstrators, was dispatched, under Murphy's guidance to arrange the bargain. Arrived at the house, South, already rendered apprehensive by the cautions that had been impressed upon him in his journey thither, had no sooner unfolded his mission than he was met with a display of virtuous indignation mingled with a tirade of abuse, and the gravedigger presented a horse-pistol at his head with threats as to what would happen if he dared to approach the graveyard in question.

Next day Murphy, full of apologies for his error of judgment, turned up at the hospital, and the unhappy South was again desired to accompany him to a similar interview in St. George's-in-the-East. On this occasion the demonstrator elected to remain in the open street whilst the body-snatcher entered into negotiations in the house of the sexton. A demure, respectable-looking man at length emerged and struck up a conversation with Mr. South. Once more, immediately the important topic was broached, he was assailed by volleys of abuse, and beat a hasty retreat attended by Murphy who pretended to share his discomfiture. No further attempts were made to dispense with the intermediation of the body-snatcher.

Murphy, although without education, was a man of very considerable ability and resource, who relied on cunning and artifice rather than the open and daring methods of some of his colleagues. He was a genial-looking Irishman, tall, stout, and strong, and was generally civil in his address and sober in his habits. The "King of the Resurrectionists," as he was sometimes called, was of an unforgiving disposition, and he seldom failed to settle accounts with another of his tribe who had played him false, however long the opportunity for revenge might be delayed.

He and another of the resurrectionists, to whom Bransby refers under the assumed name of "Patrick," had discovered a remunerative mine in a private burial ground near Holywell Mount. Acting in collusion with the gravedigger, named Whackett, the partners did a thriving business, frequently bringing away as many as six bodies in a night. Their success attracted the notice and the envy of certain of their professional rivals who determined either to be admitted to a share in the profits or to wreck the enterprise. Two of them, Holliss and Vaughan, discovered Whackett and pressed him to allow them to participate in the good fortune of Murphy and "Patrick," threatening him with exposure should he decline. The gravedigger, however, enraged at their attempts, called out to a party of labourers near by, "Those fellows are body-snatchers and are come here for the purpose of bribing me to let them raise from my ground!" Vaughan and Holliss escaped in time to avoid some very rough handling, and their next impulse was towards securing revenge for such unfair treatment. They at once laid an information at a neighbouring police-court to the effect that if officers were sent to the Holywell Mount ground they would find the graves had been desecrated, the grave-digger having sold the bodies. A crowd of people immediately set out for the graveyard, burst open the gates and commenced to dig up the empty coffins. When they discovered how well-founded were their suspicions they seized upon Whackett, flung him into an open grave, and, unless the police had intervened for his protection, would have shovelled the earth over him. The grave-digger's wife and children were dragged through a pond, his house was wrecked, and the windows of the house in which lived the innocent old ladies who owned the graveyard were smashed.

Murphy waited nearly a year before he was able to wipe off old scores with his enemy. Vaughan by that time was in concealment from the police for some other offence, and Murphy had the satisfaction of revealing his hiding-place to the magistrates and of smoothing the way to Vaughan's capture and commitment to Maidstone Gaol for two years.

One of Murphy's most famous exploits was concerned with a branch of his profession to which we have not yet referred. The collection of teeth from dead bodies was an extremely lucrative occupation, and immense sums of money were thus earned, for at that time every dentist in London would purchase teeth from these men.

One day when Murphy was talking a walk, his eye was attracted by a paved burial ground attached to a

little meeting-house, and in it a trap door leading to a vault which he felt impelled to explore. Shortly afterwards, therefore, he returned, attired in a suit of decent mourning, and obtained permission to inspect the vault that he might choose a resting-place "for his recently-departed wife." Once within he contrived, unobserved by his guide, to unfasten a couple of bolts by which the door was made secure. The same night he came back, let himself down into the vault, and, in the course of a very few hours, possessed himself of the front teeth of all the inmates. The night's work gave him a clear profit of sixty pounds.

Murphy was always a most industrious worker, and it is known that on one evening alone he disposed of twelve subjects between two London schools for a total of £144. Out of this sum he disbursed no more than five pounds apiece to his four or five assistants, so that he was certainly well over a hundred pounds to the good on the evening's work.

At the time of year when the hospital dissecting-rooms were shut down Murphy employed himself in collecting teeth, selling skeletons, and laying his plans for the campaign in the ensuing winter. He died in the early 'forties, leaving a wife and child very comfortably provided for.

R. M. W.

(To be continued.)

Appointments.

Medical School Appointments.

OCTOBER—DECEMBER, 1913.

Clinical Assistants.—Messrs. L. B. Stringer, C. H. Gould, E. D. Scott, N. Garrard, F. A. Hampton, W. H. Ogilvie.

Clinical Assistants in the Medical Wards.—Messrs. C. Sherris, E. C. W. Starling (Dr. Hale White); E. G. Martin, D. C. Scott (Sir Cooper Perry); C. R. Smith, P. R. Boswell (Dr. Shaw); R. C. Matson, C. Dean (Dr. Fawcett).

Clinical Assistants in Surgical Wards.—Messrs. F. E. R. Laborda (Sir Arbuthnot Lane); J. York Moore (Mr. Dunn); S. Wilson (Sir Alfred Fripp); G. W. King (Mr. Steward).

Clinical Assistant in Medical Out-Patients.—Mr. T. W. Sheldon (Drs. Beddard and French).

Clerks in Electrical Department.—Messrs. A. J. Drew, F. D. Annesley.

Dressers in Special Departments:—

(A) *Throat and Ear, Children, Genito-Urinary.*—Messrs. W. A. Young, C. E. Petley, L. R. Pickett, J. H. Parry, W. E. Tanner, A. Wills, J. Stephenson, C. F. Pedley.

(B) *Throat and Ear, Skin, Orthopædic.*—Messrs. A. L. Anthony, D. O. Richards, L. A. J. Graham, J. S. Cocks, J. E. Davies, W. H. Nicholls, R. W. Cushing, C. S. L. Roberts.

(C) *Eye, Nervous System.*—Messrs. L. Horsley, A. H. Harkness, A. S. Liebson, H. L. Messenger, A. Tilbury, G. L. Attwater, F. V. Bevan Brown, F. W. Lawson.

Obstetric Dressers and Externs.—Messrs. W. M. Lansdale, F. L. Spalding, S. S. B. Harrison, C. de W. Gibb, H. L. P. Peregrine, P. R. Chevreau (2 m.) (Mr. Bellingham Smith); N. H. W. Saw, F. Gilbert L. Scott, B. Burnside, H. H. Elliot, R. Sells, H. Parry-Price, P. D. Scott (Mr. Chapple).

Medical Ward Clerks and Post-mortem Clerks.—Messrs. C. P. Symonds, L. R. Broster, N. E. Kendall, G. D. Gripper, A. F. Rook (Dr. Hale White); R. A. Holmes, E. J. Cooke, R. Curle, K. L. Bates, S. W. Coffin (Sir Cooper Perry); M. Chadwick, W. A. Easton, G. B. Tarring, B. Sampson (Dr. Shaw); W. L. Partridge, C. C. G. Gibson, E. W. Bowell, A. C. M. Coxon (Dr. Fawcett. G. Noott, D. H. A. Galbraith, V. R. Hirsch, K. N. Purkis, C. H. Edwards, L. H. B. Evans, J. J. Conybeare, F. A. Knott, J. G. Jones, E. Biddle.

Surgeons' Dressers.—Messrs. K. Westman, J. F. Mackenzie (Sir Arbuthnot Lane); J. F. H. Stallman, C. H. Medlock, R. J. Quesada (Mr. Dunn); H. Q. F. Thompson, L. S. Fry, W. L. E. Reynolds (Sir Alfred Fripp); R. W. P. Jackson, H. F. T. Hogben, A. K. Day-Lewis (Mr. Steward).

Assistant Surgeons' Dressers.—Messrs. A. L. Punch, V. E. Lloyd (Mr. Fagge); C. W. W. Baxter, J. E. Clark (Mr. Rowlands); J. G. Stevens, R. N. Craig (Mr. Turner); J. Kyle, G. S. B. Long (Mr. Hughes); M. J. T. Wallis (Mr. Davies-Colley).

Surgical Ward Clerks.—Messrs. E. A. Leviseur, J. F. Carter Braine, A. W. Cocking, D. M. P. Whitcombe, A. F. G. Guinness, A. Traill, E. C. de M. Morgan, J. A. Fairclough, R. L. Portway, G. B. Dowling, A. G. East.

Student Demonstrators of Microscopical Pathology.—Messrs. W. A. Young, J. York Moore.

Pathological Assistants to the Demonstrators of Morbid Anatomy.—Messrs. W. A. Young, F. D. Annesley.

Civil.

H. W. Catto, M.B., B.S., M.R.C.S., L.R.C.P., to be Assistant Pathologist and Bacteriologist to the Island Medical Department, Jamaica.

George Steele-Perkins, M.D., Surgeon to the *Agadir*, R.M.S.P.C.

Military.

SPECIAL RESERVE OF OFFICERS.

Royal Army Medical Corps.

H. C. Rook, M.R.C.S., L.R.C.P., late Cadet Staff-Sergeant, University of London Contingent, Officers' Training Corps, to be Lieutenant (on probation), (dated September 4th, 1913).

Three Cases of Perforated Typhoid Ulcer.

CLINICAL LECTURE BY Mr. TURNER.

Last year I was called upon to operate on three cases of perforated typhoid ulcer in the medical wards of this hospital. As these each showed points of considerable interest I have chosen them as the subject of to-day's lecture. I will first give you a brief account of each case.

Case 1.—Edward James C., æt. 46, was admitted into Clinical on December 8th, 1912, under Dr. Hertz for acute abdominal pain. His condition was very grave, indeed he was so ill that it was with the greatest difficulty that any history could be obtained. The patient told us that for two weeks before admission he had suffered with abdominal pain, chiefly in the upper half of the abdomen. There had been no vomiting and his bowels had acted regularly; for a considerable part of this time he had been unable to work and had rested in bed, but had not seen a doctor. Three days before admission the pain had been much worse, and he had vomited several times during the preceding night. Before the present trouble he had for some time suffered from indigestion.

On admission the pulse rate was 120. The abdomen was distended and did not move on respiration. Above the umbilicus it was rigid and tender. On percussion there was no liver dulness. The patient obviously had general suppurative peritonitis, and, taking into account the previous history of indigestion, and the situation of the pain, tenderness, and rigidity, the probable cause of this appeared to be a perforated gastric or duodenal ulcer. He was operated upon shortly after admission. The peritoneal cavity was opened by a median incision above the umbilicus. Pus and gas escaped at once, and it was obvious that there was general suppurative peritonitis with numerous recent adhesions matting together the intestinal coils. An investigation of the stomach and duodenum showed no evidence of perforation or ulceration. A second incision was then made in the right semilunar line below the umbilicus to expose the appendix, but though the same condition of suppurative peritonitis was found, this structure showed no pathological change. The condition of the patient was now so grave that no further search for the cause of the trouble was possible. The peritoneal cavity was accordingly drained and the patient sent back to bed. He died a few hours later.

At the post-mortem examination numerous typhoid ulcers were found chiefly in the ileum; one of these had perforated and this was the cause of the peritonitis. Many of the ulcers were healing, and hence one had to assume that the perforation had occurred during a relapse.

You will have noticed that the condition was absolutely undiagnosed. No one had thought of the possibility of the case being one of perforated typhoid ulcer either before or during the operation. My own opinion at the time was that there must have been a perforation of a duodenal ulcer, which, owing to the presence of the pus and intestinal adhesions, I had been unable to find.

The chief interest of this case is that it is a true example of ambulatory typhoid. For some weeks the patient must have suffered from this disease, without himself, or indeed anyone else, being aware of it. For a considerable portion of this time he was following his occupation, and even after the perforation had occurred he walked up to the front surgery from whence he was admitted. Of course the history was very imperfect, and it is possible that if the patient had been in a condition to give a full account of his symptoms and illness, that the true condition might have been suspected.

Case 2.—Edward W., æt. 43, was admitted into Clinical under Dr. Pitt on October 26th, 1912, for malaise and fever. He had been unwell for three weeks, and had continued at work until the day of admission when he walked up to the surgery. Though no spots were observed his symptoms were fairly characteristic, and a Widal's reaction was positive. There was severe pyrexia, the temperature for some time being 105 deg. He also developed, as a complication, a severe attack of bronchitis. On November 1st, at 6 a.m., he complained of some pain in the lower part of the abdomen, which was also tender; the temperature fell to 95 deg. At first it was thought that he had had a hæmorrhage, but the abdomen became slightly rigid and tender, and at 2.30 p.m. he was seen by Dr. Pitt who thought that an ulcer had perforated. The abdomen was at once opened by an incision in the right semilunar line below the umbilicus. As soon as the peritoneum was opened a thin watery purulent fluid escaped. The cæcum was drawn to the surface, and the lower end of the ileum identified. The lower end of the ileum was then drawn from the peritoneal cavity, and a jagged looking

perforation was soon found about a foot above the ileo-cæcal valve. The opening was quickly closed by a purse-string suture of fine catgut, which was afterwards buried by a continuous Lembert's suture. A drainage tube was inserted over the brim of the pelvis where the fluid had chiefly collected, and the wound was sutured around the tube. The respiratory trouble increased after the operation, and the patient died on the evening of the following day.

In the opinion of myself and of others who saw this case death was due to the pulmonary trouble and not to the perforation; this was confirmed at the post-mortem examination, which showed the opening to be satisfactorily closed and no serious peritoneal inflammation.

Case 3.—Ernest T., æt. 25, was admitted under Sir Cooper Perry, on December 12th, 1912, for headache and general aching pains of about a week's duration. After admission the abdomen became tense, spots appeared, and a positive Widal's reaction was obtained. He had a very severe attack of the disease, and was frequently delirious. On December 22nd, at 7 p.m., he was suddenly seized with acute abdominal pain, the temperature did not fall, and the pulse rate did not increase, but the abdomen became distended and the liver dulness disappeared. I was asked to see him at 1 a.m., and decided to operate at once. The operation was carried out on the same lines as the last case; the perforation was found in the same way close to the termination of the ileum, and was closed in a similar manner, though with rather more difficulty owing to the greater friability of the intestine in this case. The operation took about twenty minutes. Next day the patient was very cyanosed, was breathing rapidly, and had frequent attacks of vomiting and hiccoughing. He died about twelve hours after the operation. This patient had a very severe attack of typhoid, and even if no perforation had occurred would, in all probability, have shortly died of the fever alone.

Perforation of an ulcer is a very serious and by no means an uncommon complication of typhoid fever. Different statistics vary somewhat, but it may be said to occur in about 3·5 per cent. of all cases and in about 12 per cent. of all cases. During the past twelve years 542 cases of typhoid have been admitted into this hospital. Of these, 46 died, and perforation occurred in 12.

Perforation is very rare before the end of the second week, but frequently occurs in the third or fourth week. It may occur during a relapse, or even later, when the temperature has come down and the patient is convalescent. Of the above cases the perforation occurred during the fourth week in Case 2; during the third week in Case 3; and during a relapse at a time which could not be ascertained from the commencement of the disease in Case 1. By far the commonest situation of the perforation is in the lower end of the ileum, usually in the terminal foot or two; it may also occur in the cæcum, or even the appendix.

Perforation in any other part of the intestine is rare. The probable localization of the lesion to within a short distance of the ileo-cæcal valve is of the greatest importance in the treatment. The opening is usually small; sometimes it is large, owing to the separation of a considerable slough; occasionally more than one perforation may be present.

We have now to consider the question of diagnosis. I have already explained that in Case 1 a definite diagnosis was impossible. All one could say here was that the patient was suffering from general suppurative peritonitis, and that the imperfect history rather pointed to a perforated gastric ulcer as the cause. Failing this, a ruptured appendicular abscess appeared the most reasonable explanation. In the other two cases, as will usually be the case, we had the important fact to go upon that the patients were known to be suffering from typhoid fever. Even with this knowledge the diagnosis is often a matter of very great difficulty. The patient may be so seriously ill with the fever that perforation may occur without giving rise to any definite symptoms, and the lesion may then be unexpectedly found at the post-mortem examination. One has to remember, too, that peritonitis may arise from other causes than a perforation during typhoid fever. It may apparently be due to organisms penetrating the intestinal wall without any perforation, or to rupture of a breaking down mesenteric gland, or as the result of typhoid cholecystitis. The most characteristic symptom is the sudden onset of acute abdominal pain usually referred to the right iliac fossa, but possibly general from the first. This is quickly followed by symptoms of collapse; the pulse increases in rate and becomes more feeble, vomiting frequently occurs, and the abdomen becomes distended. The liver dulness may disappear as was noticed in Case 3. Sometimes there is a sudden and great fall in the temperature as was noticed in Case 2. Perforation is sometimes followed by a rapid and considerable increase in the number of leucocytes; rarely a rigor occurs.

The only other complication of typhoid fever which gives rise to similar signs is a severe hæmorrhage, and this is what was at first suspected in Case 2. A considerable hæmorrhage is usually quickly followed by marked pallor. When, after a short period of careful observation doubt still exists, the case should be regarded as one of perforation, and treated accordingly. It may be well here to insist on the importance of early diagnosis and operation, even more than in other perforative lesions, the earlier the operation the greater the chance of success. Those in charge of cases of typhoid should, therefore, always bear in mind the possibility of perforation, and be continually watchful for any symptoms suggesting that it has occurred. If such appear a surgeon should at once be asked to see the patient. In Case 2 the operation was nine hours after the perforation, and in Case 3 about six hours after. Though neither of these intervals was long, we agreed afterwards that it would have been better if the operations had been done several hours earlier.

We have now to consider the surgical treatment of these cases. The patient will probably be very seriously ill and hence speed is of great importance. A small amount of general anæsthetic, preferably chloroform* is best, but if the patient's condition does not permit of this local anæsthesia may be employed.

In making the incision one has to bear in mind that the perforation is almost certainly within a short distance of the ileo-cæcal valve. In cases 2 and 3 I therefore made an incision in the right semilunar line below the umbilicus, and in each case found this most satisfactory. Some surgeons advise an incision in the mid line. The advantage of this would appear to be that if the perforation should be in an unusual situation it could be more readily reached. The former incision, however, permits of easy identification and examination of the cæcum and the lower end of the ileum. When the peritoneal cavity has been opened the cæcum is drawn up to the surface and the termination of the ileum is identified. The lower coils of this part of the intestine are drawn into the wound, and in each of the above two cases the opening quickly came into view. The intestine must be handled with the utmost gentleness. In typhoid fever the bowel has a curiously sodden and friable feel, and unless very gently handled readily tears. Apart from this any rough manipulation might easily lead to the separation of other sloughs and thus to other perforations. In each of the above cases the perforation was small and was closed by a purse-string suture. This was then buried by a continuous Lembert's suture. Fine catgut was the material employed. In case 2 the intestine was so friable that the first purse-string suture cut out. Fortunately a second suture not so tightly tied held well as did also the Lembert's suture. In each case the post-mortem showed that the opening had been satisfactorily closed.

Drainage of the peritoneal cavity is necessary. In case 3 the effusion was mainly found in the pelvis; a single tube with a wick of gauze was accordingly passed down into the pelvis. In case 2 the effusion appeared to be more generalised, and hence two drains were employed, one passing well into the pelvis and the other towards the left hand side of the abdomen. If the operation is carried out within a few hours of the occurrence of the perforation a counter incision for drainage will scarcely be necessary.

It will now be necessary to briefly consider the treatment of those cases where the perforation is very large or where the intestine is so friable that the sutures at once cut through. Should this happen two alternatives are possible; (*a*) to bring the perforated coil outside and make an artificial anus; (*b*) to excise the perforated coil. Either of these alternatives is very hopeless, but of the two the artificial anus would appear to be preferable. Should the patient survive a secondary resection might be effected later on, while the general condition of the patient can scarcely ever justify a primary resection of the bowel.

The prognosis in these cases is always exceedingly grave. You will have noticed that each of the three cases I have mentioned died. The first case, of course, was absolutely hopeless; he was practically moribund on admission. The third case was also very hopeless on account of the severity of the symptoms of the fever itself. Of the three, the second only offered any real chance of success, and here, as far as one could judge, the perforation was not the cause of death, and had it not been for the severe attack of bronchitis he would have stood a good chance of recovery. On looking up published statistics one is struck by the remarkable variation in the percentage of reported successes, and also by the large amount of success claimed by some operators. Thus* Keene

* Chloroform was given in each of these cases. On a future occasion I should prefer gas and oxygen. Dr. Shipway also informs me that he would consider this anæsthetic the most desirable.

* These statistics are quoted from Jacobson and Rowlands, p. 330, vol. 2.

quotes 83 cases with 16 recoveries, or 19·2 per per cent.; Harte and Ashurst collected 362 cases with 26 per cent. of recoveries; Goodall mentions 48 consecutive cases at the Metropolitan Fever Hospitals, with four recoveries, or 8 per cent.; Woolsey records 17 consecutive hospital cases, with a mortality of 76·4 per cent. Of these statistics one cannot help thinking that those of Dr. Goodall give the best idea of the true mortality.

In these cases one has to remember that every successful case will be published, while innumerable fatal cases are not recorded. I quite agree with the remark in Jacobson and Rowland's "Operations of Surgery"—"That it is not probable that the percentage of recoveries in any series of a large number of consecutive cases will not be above 20 for many years to come, and that this would be a brilliant success for a condition which is practically certain to be fatal unless an operation is done."

I have heard that no case of perforation of a typhoid ulcer has yet been successfully operated on in this hospital. I have looked up all the cases since 1900, and this is certainly true. since then, and before this date, recovery would certainly have been very unlikely. Of course we have very few cases—only in the period of twelve years mentioned. Still, one feels that this is a fact which one would like to see altered. How is it to be done? It is difficult to say. Perhaps I may here again urge what I have already said, viz., that a close watch should always be kept for symptoms suggesting perforation, and that the operation should be carried out at the earliest possible moment. One may go further and urge that an exploratory operation might be performed directly any suggestive symptom, such as a sudden attack of abdominal pain is noticed. An exploratory operation requires so little anæsthetic, and is so simple a matter, that even if no perforation were present no harm would probably be done, while the early closure of the perforation would offer the best possible chance of recovery.

The Christian Union.

On Monday, October 13th, the opening meeting of the Session of the Guy's Hospital Christian Union will be held at 58, Portland Place, W., at 8.30 p.m., by kind invitation of Mr. and Mrs. Charters Symonds. The Rt. Rev. Bishop Taylor Smith, Chaplain-General, has kindly consented to give an address. The invitation is open to past and present Guy's men, and it is hoped many will take this opportunity of hearing the Bishop.

The Study of Anatomy.

AN INTRODUCTORY LECTURE BY
T. B. LAYTON, M.S.

Gentlemen.—Our study of physiology began in our childhood when we realized that our mouth was the place in which to put our food, and that if we did not keep our eyes open we could not see. At some period in our existence we noticed a currant, a plum-stone, or a sixpenny piece in our fæces, which had entered our body through the mouth. None of us remember when we first learnt this, and yet it was an important stage in our career, for unconsciously it was the first physiological experiment that we did, and it gave us our first idea that certain parts of our body were linked together in their action, in other words a first idea that the body is made up of systems of organs which we now speak of as the alimentary system, the circulatory system, and so on.

When we first made this observation we probably deduced that there was an open continuous canal from mouth to anus, and this belief was strengthened by our experience of over-eating or of taking castor oil, and confirmed by us when we first cut up a rabbit or a mouse. So far we did not *know* that the human body possessed a continuous patent alimentary canal, we only *believed* it. Our belief was suggested to us because we could imagine no other explanation of the thing we had observed, and we found, on examination of the lower animals, that the belief held good for them. We may infer that it also holds good for us, but we do not *know* it until we have opened the human body and traced the alimentary canal through all its windings.

I have taken this parable of the child because it shows us two things, the difference between belief and knowledge, and the way in which we must study physiology. You only *know* of things which you have of yourselves observed, everything else you can only believe. What you see is knowledge, and so you must continually be observing. The demonstrators cannot *teach* you, they can only *show* you the way to teach yourselves by pointing out the structures of the body, and by setting you to experiment on these structures. A very large number of things you will have to take on faith, but always you must make that number as small as possible. It is impossible for any one man to make all the examinations of the body, and all the experiments on it which ever have

been done; and so a very great amount of our study is of necessity by faith. You must, however, always distinguish between the two things, knowledge and belief, and take every possible chance of converting an article of faith into a fact of knowledge. In other words you are not to accept as true anything that any of your teachers tell you. You are to store it in your brain with a polite but sceptical frame of mind, then if you ever have the chance of confirming it you will *know* it, if you have no such chance, and it fits in with other things that you have observed, you may *believe* it; but if it is contrary to the things you yourself have seen, never believe it, however eminent your teacher, and however firmly he himself believes it. You may make mistakes this way, but you will make fewer than you will if you swallow everything that is put before you, and you will learn to reason and to observe which are the only two tracks to knowledge.

We now turn again to the study of physiology. As I have shown above, everyday experience teaches even a child that certain organs are associated with certain functions, and therefore to know about the actions of the body we must first know its structure. The history of physiology repeats itself in the curriculum of the student; the foundation of physiology and its first sub-division is structural physiology; the earliest physiologists, Vesalius and Fallopius, were chiefly concerned with this structure.

Anatomy is the word which has been long used for structural physiology because the earliest means used to study it was by cutting up the body; later, other methods have been used by anatomists, but dissecting remains the first and chief method which everyone must use.

You are not, however, merely physiology students, you are also students of medicine, and this brings in another point of view from which the structure of the body must be considered. In order to know the routes by which disease may spread from one part of the body to another, and the routes by which these diseased areas may be reached, whether by drug, by current of electricity, or by the knife, topographical anatomy must be learnt. It is necessary for the doctor to know his way about the human body as well as a taxi-cab driver should know his about London. This commercial aspect of the subject is in no wise to be despised; there is sometimes, however, a danger of the student learning it to the exclusion of the functional point of view which we have already discussed. He is apt to learn a list of relations by heart or to conjure up a mental picture of a small area without thinking of the meaning of the subject as a whole. His studies then become merely mechanical, and though his knowledge may carry him through the nearest examination, yet it is short-lived and of little real value. In the dissecting-room most of your time must of necessity be applied to this aspect of the subject, but I would implore you always to carry the knowledge you learn there up to the Physiology department, and to apply what you learn in the laboratory to the body you cut up in the dissecting-room.

Let us now consider how the science of anatomy can be studied and in what sub-sections it may be divided.

There is first the study of the average adult body; this may be cut to bits and examined with the naked eye and we find it is composed of various systems of organs, arranged in certain relations to one another, and these organs all consist of certain parts which are called tissues, each more or less distinguishable to the naked eye. This is macroscopical anatomy. Further to study these tissues a microscope and special methods are necessary, and we pass from the realm of macroscopical to microscopical anatomy, which is also known as histology. This branch of the subject—as I think unfortunately—is not taught by the structural physiologist in this country, but by the experimental or chemical one. The reason is historical. There came a time when the subject of physiology as a whole became, as now, too wide a one for a single man to work at all of it. Some continued the work of the older physiologists, went on with the structure of the body and were called anatomists; others specialised rather in the mechanism of the various organs and became known as physiologists—with a big P—in its narrower sense. These found that the microscopical structure was not enough worked out for them even to start, and so they spent much time and did much good work in histology. They were also in a position to teach it, while the anatomists were still working out the macroscopical structures, comparing different bodies, and contrasting them with other forms.

Recently anatomists in their work have become microscopists as well, and very little anatomical research is now done that has not its microscopical side; in their teaching, however, the innate conservatism of our race has compelled them to keep to the naked eye.

A very small amount of study will teach any one that no single description will fit any body; that any description must represent an average

of many bodies, and so a large number of variations had to be studied in order to see whether there was any meaning in them, whether they represented racial or hereditary characteristics, or whether they were variations from use or disuse. Every here and there greater deviations from the normal may be found so much so that rather than variations they may be known as abnormalities. When we go to the lower animals we find that such abnormalities may be represented in one or other of these, and so the study of comparative anatomy is brought in to human physiology. These last aspects of the subject are intensely interesting, but they have no commercial value and are not used by the Physiologists as a basis of teaching, so that medical students do not go into them.

As you continue your study of the structure of the body you will realize that the size, form, and relations of many structures must and do vary, not only between individuals, but in the same individuals under different conditions. Therefore, to open the body but once is to get a very limited idea of all that must be learnt, especially as these relations may be altered post-mortem, or in the very act of making the examination. These variations have been studied in many ways, first by examining an enormous number of bodies. John Hunter said that he had examined thousands of bodies; you cannot see inside too many when first they are opened in the post-mortem room to learn the general disposition of the viscera. Others, again, to exclude the fallacy of changes induced by opening the body, have frozen it, and cut sections of it at various levels, reconstructing the various organs from these sections. Another source of knowledge has been the living body during operations, though here the opening is so small that some are doubtful as to the value of the method. Recently the X-rays have been shown to be very useful in studying many anatomical points; the movements of the diaphragm and heart, the positions of the alimentary viscera and movements of joints have all been examined in this way. I have spent some time in detailing the various methods used to study this kind of variations in the position of structures, because they are of extreme importance to you as students of physiology, and later of medicine; the varying relations of the nerves to bony points, of lungs in inspiration and expiration, of the heart in systole and diastole, and of the stomach or bladder when full or empty, are of everyday value when in the wards you begin to study disease.

So far we have spoken only of the adult body, it does not need much observation to realize that the infant differs from the adult in many points. This opens up to the anatomist a whole fresh field of investigation. To trace the structural differences between the adult and child, the child and infant, the infant and fœtus, fœtus and embryo, and between the embryo and single cell formed by the fusion of the male and female elements.

This is the study of development and embryology, and one about which you must know something to understand the deformities you will meet with later, and also many adult structures or relations which otherwise seem to have no meaning in them. But as the earlier stages of embryology were studied, the striking resemblance of the human with the monkey, the dog, or the rabbit embryo were noticed. These facts were brought into line with the theory of evolution, and as a result we have two distinct branches of study which may be followed—Phylogenesis, or the evolution of man from lower forms, and ontogenesis, or his development from the single cell. The former you will not meet with in your classes, and yet I advise you to dip somewhat into it in your spare time, it will give you a wider understanding of your subject, it will make you conversant with modern lines of thought. Ontogenesis is the branch which you must follow, and like the study of the adult body we shall find it divided into two parts—histogenesis or the development of the tissues from the primitive cells and organogenesis, or the development of the various physiological systems from their earliest appearances.

In my parable of the child I pointed out how our first dissection of mouse or rabbit may have helped us in our conception of our own alimentary canal. This help from the lower animals is one which is much used in physiology; the Physiologist cannot pith a human being on whom to examine reflexes. The anatomist cannot kill a woman so many hours or days after connection to obtain a fœtus of age exactly known. The material of the anatomist under this head is, and always must be, limited. Such material as he gains is uncertain as to dates and times, and so he must supplement his knowledge of the processes in the human being by analogy from other animals.

We have now, I think, considered all the many aspects of structural physiology. I would add a word of warning as to how you are to study it. I began my argument by showing that the first analysis of the body must be into

systems each more or less functionally distinct, but I would warn you not to carry this too far. Each organ is dependent on the others for its proper function. I would not have you learn a muscle at one time and a nerve at another; I would have you learn muscle and nerve together, if possible, with the corresponding part of the central nervous system at the same time. I would not have you learn the stomach without knowing the vessels from which it receives its blood or the vessels into which its lymph is drained. More than that, you must remember that many organs subserve two functions, and belong, therefore, to more than one system of the body. The pharynx forms the alimento-respiratory cross road; the larynx is part of the respiratory system as well as the organ of phonation; every bone within the body is a part of the circulatory system from its formation of blood cells as well as part of the skeletal system. These points I would have you remember in every structure that you dissect.

Correspondence.

To the Editor of Guy's Hospital Gazette.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—Ed., G.H.G.]

Renal Surgery.

Sir,—The letter *re* Renal Surgery in your last issue, and signed by "A Guyite of 45 Years Ago," prompts me to again trespass on your kindness, if I may do so.

Whoever he is it is pretty clearly evident that he was at the hospital about my time, and appears to know somewhat of my early career.

Yes, to me they were struggles indeed. My early education was at the local village school—excellent in its way as far as it went; just "the three R's." I had a great wish to become a doctor, but there was that one big obstacle in the way—education. However, help came in an unexpected way. I happen to come of an amateur musical stock, with the *gift* of reading music at sight. There was a vacancy in a parish church choir in Canterbury, for which there were three candidates, at the large stipend of five pounds *per annum!* I was appointed, and sang there for two years. With those ten pounds I purchased a then well-known work, *Cassell's Popular Educator*, and other necessary books, by means of which I was enabled to pass the Preliminary Arts Examination at the Apothecaries' Hall in September, 1866. I entered Guy's the next month, just forty-seven years ago!

All my life I have been, and am still, an early riser It was from 4 to 6 a.m. that I used to study for the Arts Exam., the daytime being at work in my dear old father's business. And the mention of him reminds me of his astonishment when I asked him to find me some rabbits, and disclosed to him generally my scheme about Renal Surgery. The dear old Dad hesitated, and I could feel that he, too, began to doubt my sanity! At last he said, "All right, my boy, you must be your own architect." I ought to add, however, that included in that large meeting of the Physical Society on that 9th of October, 1869, in the old Chemical Theatre, was "Richard" himself—we used to speak of and to him in that familiar way—to hear his boy, your humble servant, read his paper. He wasn't given to praise his boys and girls, but we all knew that he *did* enjoy himself *that* night! I remember him once breaking that silent rule of his, and that was when we first met after I passed my "final" at the College (November, 1870)!

So my kind friend, "a Guyite of 45 years ago," was not far wrong as regards my early struggles in education. Professional Examinations were no trouble; I never prepared specially for them. In all my professional career I have always striven, in the *first* place, and *before any other consideration*, to merit the good opinion of my fellow-practitioners, and *secondly*, to try and do my duty to the public to the best of my ability.

Apologising for the length of this letter,——I am, Sir, yours very truly, F. G. LARKIN.

P.S.—By the way, I ought to have mentioned the fact that all my experiments were done at my dear old home in East Kent, and *not* any of them at Guy's Hospital. I used to go home about every other week-end, and do two or three operations at the time. It was "a bit of a business" having such a lot of rabbits sent up for exhibition on that memorable night—and, to add to the difficulty, I well remember one of them had just had young ones; so we had to make two "flats" into one to accommodate the whole family in the rather large "house" with "apartments," into which the case was divided.

The late Dr. Milward.

Dear Sir,—May I through the pages of the Gazette ask all Guy's men to give their votes, at the forthcoming elections for Epsom College, to Wilmot Milward, son of the late Dr. Courtenay Milward, whose early death has left his family without provision for the future. There are three children to be educated. Many old Guy's men will recollect that Mrs. Milward was a Guy's nurse, so that the family has a double claim on us.

Votes can be sent either to Mrs. Milward, 5, Glossop Road, Cardiff, or to me.—Yours faithfully,

Roxeth House, WHEELTON HIND.
Stoke-on-Trent,
Sept. 30th, 1913.

On Midwifery in Rhodesia.

AN EXTRACT FROM THE LETTER OF A LADY RESIDENT WHO IS NOT A NURSE.

"I am afraid this will be rather a long letter, as I want to tell you an experience I had yesterday as a comparison to your work, and unless I describe it pretty fully it would be spoilt.

"The day before yesterday a native working on our farm came to G. [the husband] and me, saying, 'Umforzi picannin lapa ikona puma,' which means, 'My child has a baby here (pointing to his stomach) and it won't come out.' He asked for some medicine, so I gave him some cascaras. I thought if those folk did not know more about baby-bearing than I did, they must go about with their eyes shut. (The black population of this country increases twenty-four times as quickly as the white.) Yesterday Mrs. Roberts [the only other white woman except the writer of this letter within 17 miles] was having a picnic by the kraal where this woman was, and they called her in. She sent a note to the store-keeper to ask if he knew anyone with experience. Of course, the boy came to us on the way to the store, so I packed up what I thought *might* be useful—towels, soap, cotton-wool, boracic ointment, wide bandages, and sal volatile—and went to see if I could help because we couldn't think of anyone else. G. took me down.

"At the kraal, round the door of the hut were twelve other women, all sitting on their knees and heels, all with babies on their backs, and all trying to peer in at the door. The hut was very low, and you had to bend right down to get in the doorway. There were no windows. I went in, but at first I couldn't see anything, the walls were quite black with smoke; there were five black women kneeling round the walls; there was a wood fire burning on the floor in the middle of the hut. (I am sure the hut was only eight feet in diameter, and round, as they nearly all are.) The smoke from the fire nearly choked me besides making my eyes water till I was blind. Just behind the door with her feet towards it was the woman, on the floor, 'wid nodings' on. Another woman was supporting her back and holding the hand of the baby which had been born thirty-six hours. I went to find Mrs. R. to propose that I should scrub my hands and try and push that limb back, try and straighten the child, and then try to get it out.

"We were both as ignorant as asses about it, but she is a good lot older than I and has two children, so I wanted to feel she was a bit responsible if anything dreadful happened, and I didn't want her to think I wanted to go haphazard at the thing. She suggested waiting for the message from Meltzer (the store). It came; he couldn't get anyone. Then she suggested waiting for another boy who had gone to the Native Commissioner at Nyamdhlouvu. He came, saying the N.C. could also get no one. Then Mrs. R. suggested we should have a cup of tea first. This we did; then we went down wishing we were not so ignorant. I told Mrs. R. she must be inside ready to give sal volatile in case the woman collapsed.

"When we got there we heard to our great relief (but secretly a little disappointed, perhaps) that the baby was born dead. I fancy we ought to have tried artificial respiration, but had no idea how to start. The patient herself seemed quite alright, and talked away happily enough to us, but we couldn't understand a word.

"The fact of the matter is that we couldn't help, although we were so civilized, and the moral is that any woman who means to settle in an uncivilized land ought to know something about nursing, and I think a course for the C.M.B. would be an excellent start.

"I am telling you all this because it is really instructive. The whole thing was absolutely primitive; there was nothing that had been brought by the white man except the door, and that they would have done jolly side better without. It was the only means of getting light and air into the place, and when I knelt by the woman I had almost to shut it. I was very helpless, I'll own, but not nearly so as Mrs. Roberts; perhaps that is because I have hospital nurses for sisters.

"I suppose we are descended from tribes as primitive as these, and we've built on our fathers' brains until we have the obstetric theatre and cleanliness and wonderfully clever people.

"But I still cannot help musing on the facts that there are deaths in the obstetric theatre and always pain. Whereas, if we had not troubled to become civilized and clever we might be like women where infant mortality is very low, and the women go into the bush, bear their babies, and bring them home on their backs.

"People say it is a pity to educate these people, that they are happy enough as they are. I cannot think that, as, though they have no sorrow, they have no joys either. They play no games, their one amusement being a 'beer drink.' This means a visit to another kraal, drinking as much beer as they can, and shouting and dancing to tom-toms all night.

"The women are very independent and will not work much, but they are far superior to the men in physique and work, and my idea would be, not to teach the men the Bible (except, perhaps, about the washing seven times in Jordan) and reading, writing, and arithmetic, but to teach the girls the advantages of cleanliness and the comfort of things we enjoy, and then house-work. They would educate their men all right."

Papers by Guy's Men.

H. C. Cameron, M.D.: A Lecture on the Causes of the Failure of Women to nurse their Infants at the Breast.—*Lancet*, September 27th, 1913.

Major C. E. Pollock, R.A.M.C.: Report on XVIIth International Congress of Medicine, Section xx., Naval and Military Medicine.—*Journal of the R.A.M.C.*, September, 1913.

Hastings Gilford, F.R.C.S.: The Effects of the Ductless Glands upon Development.—*Lancet*, September 6th, 1913.

T. B. Layton, M.S., F.R.C.S.: Anæsthesia in Acute Inflammations of the Mouth and Pharynx.—*Lancet*, September 13th, 1913.

F. Gowland Hopkins, M.A., M.B., D.Sc., F.R.S.: An Address on the Dynamic Side of Chemistry.—*British Medical Journal*, September 20th, 1913. Also Abstract, in *Lancet*, September 20th, 1913.

Lawrie McGavin, F.R.C.S.: A Case of Head Injury.—*Clinical Journal*, September 3rd, 1913.

Ditto: A Case of Carcinoma of the Pelvic Colon, Ovarian Tumour, and Appendicitis, Necessitating Repeated Abdominal Section.—*British Medical Journal*, September 20th, 1913.

W. T. F. Davies, M.D., B.S.: A Method of Operating for Radical Cure of Inguinal Hernia.—*British Medical Journal*, September 20th, 1913.

E. H. Starling, M.D., F.R.C.P., F.R.S., and Another: The Part Played by the Lungs in the Oxidative Processes of the Body.—*Journal of Physiology*, August 18th, 1913.

E. G. Reeve, M.R.C.S., L.R.C.P.: The Treatment of Phthisis by Intensive Nascent Iodine Administration.—*The Practitioner*, September, 1913.

H. F. Renton, M.D., B.S.: An Unusual Case of Cerebral Abscess.—*Lancet*, September 27th, 1913.

A. S. Blundell Bankart, M.C., F.R.C.S.: The Treatment of Acute Poliomyelitis (Infantile Paralysis).—*British Medical Journal*, September 27th, 1913.

W. Sampson Handley, M.S., F.R.C.S.: Introductory Lecture on Medicine as a Liberal Education.—*Lancet*, October 4th, 1913.

C. F. Fraser, Capt. I.M.S., M.D.: Some New Methods of Treatment introduced by the Staff of the Government Maternity Hospital, Madras.—*Indian Med. Gazette*, September, 1913.

G. H. Hunt, M.B., B.Ch.: Case of Complete Heart Block.—Proc. Royal Soc. Med., Clin. Sect., June, 1913.

Ditto: Case Illustrating the Prognosis of Extrasystoles.—*Ibid.*

P. Turner, M.S., F.R.C.S.: Renal Calculi in both Kidneys.—*Ibid.*

From Clinical.

A Case of infection with B. Ærogenes Capsulatus.

Elizabeth Betsy S., aged 2 weeks, was admitted to Clinical with umbilical sepsis and mastitis neonatorum.

On the day after admission it was noticed that the front of the neck and upper part of the chest was swollen, and palpation of this part gave the crackling sensation characteristic of surgical emphysema. There were no signs of inflammation of the tissues.

The condition resembled that which is occasionally seen in tracheotomy cases, *i.e.*, double pneumothorax associated with emphysema of the neck, the air passing down by way of the deep cervical fascia and causing rupture of the pleura. In this case no operation or subcutaneous infusion or exploration with a needle had been performed.

On the following night the swelling increased, and the child became cyanosed and died.

At the post-mortem no abnormality of the air-passages was found to account for the presence of air in the tissues. There was a complete bilateral pneumothorax, and collapse of both lungs. Over the surface of the lungs were several large blebs of air, the largest being about the size of a filbert-nut. It was probably the bursting of these blebs, and the resulting escape of air from the alveoli which caused the pneumothorax.

[In Clifford Allbutt's "System of Medicine," it is stated that pneumothorax, due to the production of gas by bacterial activity, must be of infinite rarity, and has never been seen by the author, and that the explanation of its apparent occurrence is that a perforation of the pleura has been present, though not discovered post-mortem].

An emulsion of the spleen was made and injected into a rabbit's vein, the rabbit being then killed and placed in an incubator. On the following morning the rabbit was found to be swollen up so as to resemble a sausage, its subcutaneous tissues being full of gas, and the infecting organism proved to be bacillus ærogenes capsulatus.

A. C. C.

Clinical Demonstration.

On Thursday, October 16th, at 4 p.m. in the Clinical Theatre, Mr. Layton will show the following cases:

Bilateral adductor paralysis of larynx.
Bilateral abductor paralysis of larynx.
Bilateral abductor paresis of larynx.
Unilateral abductor paralysis of larynx.
Fixation of aryteno-epiglottic joint.
Carcinoma of the vocal cord.

Present or past throat dressers will be able to examine the larynxes; each should bring a frontal mirror if he possess one.

"The District," 1913.

2.0 a.m. — What, another card, Grey? No, not Jamaica Road again to-night; why, I've only just got back from there. "Primip." did you say? No, not in ten minutes, worse luck. Ah, well, tell the man—woman, was it?—well, tell the woman—asked me to hurry, did she?—because it's urgent, is it?—well, give her the famous message: "She need not wait."

2.15 a.m.—Anyone else out now? No, not twins again. Charity out, too; just back; oh, I see. Tea in the Front now. Yes, it's a dog's life.

2.20 a.m.—Evening, Robert. Yes, fine night. What? Yes, deuced cold, isn't it? No lamp? Why, no; nor it is; but you see it's one of these electric ones; you just press the button when you see the arm of the law round the corner. No, I'll be careful next time. Yes, the kiddies are moderate, but none the better for Lloyd George. What? Yes! Oh, Lloyd George! Yes, well, so do I. So long, Robert.

2.30 a.m.—Evening, mister. How's the missus? Oh, don't *you* worry. Fifteenth? Oh, well, that's all right. Upstairs, front room? Yes, I'll be careful going up.

3.30 a.m.—All serene, mister; twins, one of each. What? Good Gawd! Yes, I *do* mean it! Go and listen for yourself; they've got their mother's lungs. No, you needn't blame me; you can thank your stars you didn't have to fetch the "'ead physician" all in a hurry. Yes, the "tall fair genulman," that's the one. Yes, he does look clever, doesn't he? Very 'andy too with instruments. What? Lloyd George! Oh, no I won't; it's too late for politics. No lamp? Why, no; nor it is; but you see it's one of these little electric ones; you press the —; yes, that's it. What? The kiddies want a ticket for the Christmas Tree? Well, get their faces cleaned up a bit, and let me see them in the morning; yes, to-morrow morning if I can get time. Beastly weather. Yes, things are a bit busy just at present; oh, don't mention it; my dear sir, I *like* it!

3.35 a.m. — Evening, Robert. Yes, what? Cold, isn't it? Yes, twins, one of each. No lamp? Why, no; nor it is; but you see it's one of the little electric ones; you just press the — *Good*-night, Robert.

3.45 a.m.—Good evening, nurse. No, I won't have any tea, thank you. Yes, twins again, worse luck. All Lloyd — What about him? Oh, too late for politics, and, by-the-way, may I just telephone to the College? That the College? Yes, well, I'm in the Surgery; if another card — What, another card! Come! —!— I beg your pardon, nurse. No! Not Jamaica Road *again*, why I've—not another prim. . . A-a-ah!!

(Collapses into nurse's arms, babbling incoherently.)

T.

Guy's Hospital Missionary Society.

The object of this Society is, as its name implies, to foster and increase among Guy's people that true Christian ideal which is the missionary spirit. With this object its activities are used in two directions: the one local and personal, the other widespread and collective. The local work of the Society is in the form of Daily Celebration of Holy Communion in the Chapel with intercessions for Home Missions on Wednesdays and for Foreign Missions on Fridays. Quarterly Intercession Papers are also distributed to those who will undertake to use them.

The general work is carried on by means of subscription of one shilling from each member. The money thus collected is expended partly in helping blind children among the Aïnnu peoples of Northern Japan, partly in providing presents for members of the Society who are going out to work in the Mission field, and also in the purchase of various Missionary magazines.

There is an idea abroad that the membership of the Society is restricted to nurses. This is entirely a mistake; the Society is meant for both nurses and students, and the officers will welcome both men and nurses who are interested in Missionary work. Meetings are held monthly, and addresses by competent speakers on their own experiences in Mission work are a prominent feature.

The present officers of the Society, who will be very pleased to obtain new recruits, are:—President, Rev. A. E. Popham. Secretary, Sister Clinical. Treasurer, Mr. H. H. Elliot.

Notices.

The Historical Medical Museum.

In response to numerous requests it has been decided to defer the closing of the Historical Medical Museum until October 31st. During the month of October it will remain open from 10 a.m. to 6 p.m. daily, and from 10 a.m. to 1 p.m. on Saturdays. After this date it will be closed for a few months for re-arrangement as a permanent Museum. It is proposed to reopen the Museum in its permanent form in the spring of next year.

Beit Memorial Fellowships for Medical Research.

Notice is hereby given that the Fifth Election of Fellows will take place on or before 1st January, 1914. Not more than Ten Fellowships will be awarded. Applications must be received on or before the 15th October, 1913. Forms of application and all information may be obtained by letter only addressed to The Honorary Secretary, Beit Memorial Fellowships for Medical Research, 35, Clarges Street, Piccadilly, London, W.

Royal Army Medical Corps,

ENTRANCE EXAMINATION.

An examination for not less than twelve commissions in the Royal Army Medical Corps will be held on the 28th January, 1914, and following days. Applications to compete should be made to the Secretary, War Office, not later than the 19th January, 1914. The presence of candidates will be required in London from the 26th January, 1914.

A copy of the Regulations for admission to the Royal Army Medical Corps, and a form of application can be obtained on application to the Secretary, War Office.

Charles Oldham Prize in Ophthalmology.

This Prize, of the value of £30, will be awarded in June, 1914. Candidates must have completed twelve months' ward work, and must at the time of entering their names be unqualified.

The Examination consists of two parts: a thesis and an oral and practical examination. Candidates must submit the subject of their thesis to the Dean, for the approval of the Examiners, on or before the 1st December, 1913, and the theses must be delivered before the second part of the Examination is held in the first week of June, 1914.

Guy's Hospital Medical and Dental Schools, 1913.

The following Entrance Scholarships and Prizes have been awarded:—

Senior Science Scholarship for University Students.—£50. Arthur Gerard East, St. John's College, Oxford.

Junior Science Scholarships.—£120. Eric Clark Hinde, Preliminary Science Class, Guy's Hospital. £60. Frederick Currer Miller, St. Paul's School, West Kensington.

Entrance Scholarships in Arts.—£100. Eric Roland Webb, Dean Close School, Cheltenham. £50. Gordon Frank Peters. Certificate. Myles Wheeler-O'Bryen, Oratory School, Edgbaston.

Open Scholarship in Dental Mechanics.—£20. Hugh Muir Smith.

Scholarship in Dental Mechanics for Pupils of Guy's Hospital.—£20. George Dee.

The Royal Society of Medicine.

(SECTION OF ODONTOLOGY.)

Regulations for Grants in Aid of Scientific Research.

1. That the grants exist for the furtherance of scientific research in connection with dentistry.

2. That all grants shall expire on May 1st next following the date on which they are made, when a statement of expenditure shall be forwarded to the Hon. Secretary, 1, Wimpole Street, W.

3. That no part of any grant shall be applied in payment of personal expenses in connection with the research for which the grant has been made, unless a resolution to that effect has been duly passed by the Committee. Every recipient of a grant shall be deemed to have notice of these rules.

4. That when the whole of the expense of the inquiry has been provided by the Committee the result of the investigation shall be the property of the Section of Odontology of the Royal Society of Medicine.

In any case in which the author desires to publish a report of work done under a grant from the Committee, elsewhere than in the Transactions of the Society, it shall be a condition of the grant that the permission of the Committee be first obtained, and the following note be affixed to the published report:—

> *Towards the expenses of this research a grant was made by the Section of Odontology of the Royal Society of Medicine.

5. That apparatus purchased with the grant shall be the property of the Royal Society of Medicine, and be returned at the expiration of the grant, unless the Committee shall otherwise determine.

6. That a report shall be furnished to the Committee by the recipient of the grant (or an interim report if the object of the grant be not then attained) on April 20th, following the allotment, containing:—

(*a*) A brief statement of the report of the Scientific Grant Committee, showing the results arrived at or the stage which the inquiry has reached.

(*b*) A general statement of the expenditure incurred, accompanied so far as is possible, by vouchers.

(*c*) A list of the instruments, specimens, etc., purchased or obtained out of the grant or supplied by the Committee, which are still in the possession of the recipient.

(*d*) Reference to any Transactions, Journals, or other publications in which the results of the Research have been printed.

(*e*) If a renewal be desired an application should be sent at the same time.

Books.

In our last number we gave a list of some of the chief firms who publish medical works. From this list we inadvertently omitted the names of Messrs. Baillière, Tindall & Cox, who are responsible for the issue of perhaps more medical books than any other firm. One recalls, almost without thought, Rose and Carless's Surgery, Green's Pathology, May and Worth's Diseases of the Eye, and several other very well known works as being on their list.

Reviews, etc.

Protein and Nutrition. By Dr. M. Hindhede, Director of the Hindhede Laboratory for Nutrition Research established by the Danish Government. Messrs. Ewart, Seymour & Co. Price 7s. 6d. net.

This book originally appeared in Danish in 1906, but the present translation contains in addition some account of recent observations.

Dr. Hindhede's interest in the subject of nutrition originated from the observation that the farmers of his native country, Jutland, lived a healthy, energetic life on a diet which contained far less protein than the 120 grm. a day which was then supposed to be the minimum for efficiency. He adopted for himself and his family a diet similar to that of the farmers, and has continued it for seventeen years with excellent results. This diet is mainly vegetarian, with a considerable amount of fat, but none of the ordinary articles of diet are rigidly excluded. The average protein allowance works out at about 70 grm. a day for an adult man with an energy consumption of over 3,000 calories a day, so that about one-eleventh of the energy only is derived from protein. This diet is very economical, costing less than sixpence a day per person. From extensive observations on his family and others, he concludes that even on a strictly vegetarian diet the amount of protein is sufficient unless the materials are specially chosen for their low protein content, and that this applies to children as well as adults. He does not favour the vegetable foods that are richer in protein, such as dried peas and beans, since they are relatively indigestible.

The objections to materials rich in protein, and especially to meat, are: firstly, that as a source of energy they are absurdly expensive; secondly, that in considerable quantities they have a decidedly toxic action; thirdly, that their use involves a waste of energy in metabolising and excreting the resulting waste products.

In the earlier part of the book a critical account is given of previous work on diet in which the author shows the fallacies in the experiments and arguments that have been used in support of the view that a large allowance of protein is desirable. Voit's own work was biased by his theories and his experiments were too brief. Others have made observations which showed that Voit's view was wrong, but have not had the courage to upset existing views. The disappearance of beri-beri from the Japanese Navy, when the allowance of protein was greatly increased, was not due to the protein, but to the increased supply of vitamine involved by the change of diet. A similar explanation accounts for the improvement in the "underfed" children of towns when their diet is altered. It is not the increase in protein, but the increase in vital principles which benefits them. They would do equally well on a diet consisting largely of fresh vegetables. The author is in agreement with Fletcher and Chittenden as to economy of protein only. He is not enamoured of excessive chewing, nor do his results point to a great economy of energy such as Chittenden found.

An account is also given of recent experiments carried out in the author's laboratory in order to determine the absolute minimum of protein on which nitrogenous equilibrium can be maintained. The most convincing period out of a long series is one of eighteen days during which an active man absorbed 3,810 calories daily with only 3·62 grm. of nitrogen, or 22·6 grm. of protein, and actually showed slight retention of nitrogen. The diet consisted of potatoes and margarine with some onions, and was not unpalatable. There were no ill effects.

Dr. Hindhede suggests that similar diets consisting mainly of potatoes should be useful in gout and other conditions in which nitrogenous metabolism and excretion are disordered and has had good results from their use.

The book is well written and is not too technical for the layman. As it forms the best exposition in our language of principles which are of enormous economic and therapeutic importance, it deserves to be widely read.

Clinical Pathology. By P. N. Panton, M.A., M.B., B.C. Messrs. J. & A. Churchill, London. Price 12s. 6d. net.

Excellent accounts of the uses of simple observation, palpation, percussion, and auscultation can be found in older books. When, however, dealing with laboratory methods of clinical importance these older books often leave imagination stimulated, but unsatisfied. The author of the work under discussion has endeavoured with considerable success to describe in detail a large amount of useful technic, pointing out its applications to clinical medicine.

The whole is rendered intelligible and interesting by short concise accounts of the associated pathological process. The book should be read by those who wish to acquire the essential minimal knowledge of modern methods and do not wish to be burdened by the complexities of the larger text-books on the subject.

Papers received.—Hospital, Journal of Clinical Research, Polyclinic, Nursing Times, St. Bartholomew's Hospital Journal, The Clinical Journal, University College Hospital Magazine, New York State Journal of Medicine, Medical Press, The Prescriber, Broad Way, The Stethoscope.

Guy's Hospital Rugby Football Club.

A Foreword.

The Rugby Football Club has begun its work this season, and the usual exhortation to general keenness must be made. But this time more than the ordinary appeal is called for, as for the last two seasons there has been somewhat of a lack of real interest among many of the players.

Surely it is time for this to end, as a special effort will, for several reasons, have to be made by one and all this year, if Guy's are to have any hope of retaining the Cup. We know that the other hospitals are making a special effort to terminate the supremacy of Guy's this year, and there is also the fact that, as a result of the Cup Tie draw, we meet St. Thomas's in the first and London in the second round, we will have our work cut out to survive till the Final.

As regards our prospects, they seem quite good, if the teams will set about it in the right way, and this refers to all of the 1st, 2nd, and 3rd XV's.

Behind the scrum most of the players of last season are available in Millett, Curle, Rook, Broster, and Medlock, and there is the very valuable addition of Steyn, the Oxford blue.

It is forward that there will be most trouble, and if we cannot produce a scrum that will occasionally give our halves the ball, we can scarcely hope to repeat our success of last season. Weight and honest push are what are most wanted; last year the lightness of our scrum was its weakest point. This year the same men are available, except that the sturdy form of W. Stranack will be much missed in the pack.

Heavy forwards are wanted most, and the club officials are most anxious to give everyone a trial, so that no one can say they have not had a chance. So it is hoped we shall soon find what we want, so as to give the teams a full season's practice together.

GUY'S HOSPITAL v. CATFORD BRIDGE.

This time-honoured fixture commenced the season at Honor Oak Park on Saturday, October 4th, and Guy's were at once able to turn out a good side, which says much for the loyalty and enthusiasm of the football men. It was good to see S. Steyn in the Hospital jersey, and L. R. Broster, who was suffering unfortunately from a bad knee and therefore unable to play, turn up and "take a flag." Guy's men turned out in fair numbers to see the Hospital score a good win. It was very appropriate that C. H. Medlock should score the first try; it came from a cross-kick by H. Millett. A few minutes later Medlock gained another try, but this was the last movement in some very fine passing by the three-quarters. A. F. Rook got in beneath the posts just before half-time, and two of the tries having been converted, Guy's were 13 points at the interval.

Resuming, Catford could not get going at all; they were not very strongly represented, and the fact that our forwards held them at all points practically settled the game. C. L. Curle, with characteristic dash, put on two tries, and Roberts, after playing excellently himself and leading his men with good judgment, gained a very popular try. Then came a good opportunity for S. Steyn to draw his first blood for the Hospital. Gathering a pass nicely, he made for the shortest way to the line and gained a try, which was loudly applauded. Medlock sent across a judicious punt for A. F. Rook to gather and run in for the last try. It was very neatly done. Again two of the tries were converted, so Guy's ran out winners by 4 goals 4 tries (32 points) to nil. Team:—

Guy's.—H. Millett (back); S. Steyn, C. L. Curle, R. Crook, A. F. Rook (three-quarters); C. H. Medlock, M. S. Hopson (halves); C. S. L. Roberts, O. Parry-Jones, M. Tweed, A. Liebson, C. H. Laver, — Kidman, E. Llarena, M. P. Haynes (forwards).

Remarks.—It is just a little too early to say much or criticise, but the team with one or two alterations forward will become a great one. The centres are very promising. Let them both remember to go straight, and then they will be invaluable to Steyn and Rook. Medlock and Millett are as good as ever; Roberts, Parry-Jones, Tweed, and Laver the pick of the forwards, but all cannot be in condition so early in October.

Change of Surname.

By a deed poll, dated November 9th, 1910, Lieut. Framroze Jamsetjee Kolaporewalla, M.R.C.S., L.R.C.P., I.M.S., relinquished and abandoned the use of his said surname Kolaporewalla, and then assumed and adopted and determined thenceforth on all occasions whatsoever to use and subscribe the surname of Kolapore instead of the said surname of Kolaporewalla.

Births.

TOMES.—On September 28th, at 65, East Dulwich Road, S.E., to Mr. and Mrs. Edgar Tomes, a son.

PHILLIPS—On September 20th, at Bethlem Royal Hospital, London, to Dr. and Mrs. Porter Phillips, a daughter.

Marriages.

BENNETT—HALL.—At St. Mary Abbot's, Kensington, on Thursday, October 2nd, R. S. de Courcy Bennett, M.R.C.S., only son of Lieut.-Colonel Bennett (late) R.A.M.C., and Mrs. Bennett, Burrow Lodge, Plymouth, to Ruby Montagu, youngest daughter of the late Colonel Montagu Hall, Royal Munster Fusiliers, and Mrs. Montagu Hall, Kensington.

SANDISON—GOLD.—On Thursday, September 4th, at Aberdeen Road Congregational Church, Croydon, by the Rev. Alexander Sandison, father of the bridegroom, Alexander Sandison, M.B., B.C., B.Sc., to Esther Catharine, eldest daughter of R. W. Gold, Esq., of Croydon.

G. T. M.

GUY'S HOSPITAL GAZETTE.

VOL. XXVII., No. 661.] OCTOBER 25, 1913. [SIXPENCE.

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Passim.

WE have to mourn, since October 15th last, the retirement of Dr. Newton Pitt from the active Staff, and to record his promotion to the Consulting Staff. As the recent dinners to Dr. Pitt, and the numbers who attended his last round have shown, his retirement is a matter of great regret to us all. We shall miss his kindly personal interest, his never failing courtesy, and, above all, his keen and stimulating personality. Dr. Pitt's acute clinical observation, his profound learning, and his wonderful energy are indeed a combination, the loss of which the Hospital and School will feel for some considerable time.

Dr. Pitt retires under the age limit, which decrees the resignation of the active staff at the age of sixty, but the hand of time has dealt lightly with him, and he neither looks his age, nor, if one may judge from the energy with which he was wont to bound up the Colonnade steps, does he feel it. We offer him our very sincere regrets on his resignation, and wish him many more happy and useful years in which he may continue to add to his own reputation, and, by reflection, to that of his Hospital. We also hope that he will not cut himself off from all his hospital associations, but continue to grace with his presence as many as possible of the hospital functions. It is, of course, unnecessary for us to say how welcome he will be.

Dr. Pitt came down to Guy's from Cambridge in 1877. He dressed to Sir Henry Howse, and took his M.R.C.S. in 1881 and the M.R.C.P. and M.D. in 1884. He was appointed Assistant Physician in 1887 at almost the same time as Sir Cooper Perry and Dr. Woolridge. He became Full Physician in 1898, when Sir James Goodhart retired from the active staff.

THE last round was made in Stephen on the afternoon of Tuesday, October 14th. The function was, if one can justly apply the term to so sad an occasion, a thoroughly successful one. That is to say, Dr. Pitt was accompanied by a large crowd of his old house-officers and clerks, all animated by common feeling of admiration and affection for their old "chief," and all full of regret at his departure. Nor was Dr. Pitt himself unmoved at the thought that this was the last occasion on which he would participate in "the practice of the Hospital." Indeed, he gave us a little glimpse of his feelings in a short valedictory address at the end of the afternoon's teaching.

He demonstrated on a small group of specially selected cases, among which were the following:

1. A case of syringo-myelia with hæmorrhage into the central cavity.
2. A case of enteric fever with severe toxic symptoms.
3. A child with pseudo-leukæmia infantum.
4. A new growth of the lung.
5. A case of subphrenic abscess.

Tea was provided for the visitors at the conclusion of the round by Sister Stephen, and among those present were Mrs. Pitt and the Misses Pitt.

A copy of the Catalogue of the Library of the Society of Apothecaries by W. Bramley Taylor, Master of the Society and Honorary Librarian, edited by J. E. Harting, and published this year, has been presented to the Wills Library by the compiler. The Library contains about 1,700 books, and is especially rich in herbals and pharmacopœias. Among the former may be mentioned, Brunfels, 1530; Clusins, 1601; Coles, 1657; Culpepper, 1651; Dodsens, 1578; Durante, 1585; Fuchs, 1542; Gerarde, 1597 and 1633; Johnson, 1633; Lovell, 1659; Lyte, 1578 and 1595; Pancovius, 1654; Parkinson, 1629 and 1640; and Turner, 1551.

The editor in his introduction states that the library "is not, and does not profess to be, an up-to-date scientific library, but a collection of old books brought together in the course of many years, and dating from about the end of the 15th to the middle of the 19th centuries." We notice that two incunabula are included in the collection. These are J. Cuba's Hortus sanitatis, de herbis et plantis, de animalibus et reptilibus, de avibus, etc., printed at Mainz in 1491; and the Speculum Historiale of Vincent of Beauvais, a Dominican monk of the 13th century, printed at Venice in 1494.

Dr. Bramley Taylor, who compiled the Catalogue, is an old Guy's man; he qualified in 1869, and although he has retired from practice, he has not given up his active interest in medicine and related subjects. He was elected Master of the Society of Apothecaries in 1912.

We publish elsewhere in our columns a notice of the Guy's Hospital Ball, to be held this year on November 21st. It will again be held at Prince's, and we hope that, as in recent years, it will be an unqualified success. This Ball has become the chief social function of the Hospital winter, and has become more and more popular coincidently with the present vogue for dancing. We would remind intending dancers that the notice to the effect that the Committee reserve the right to increase the price of the tickets is no idle threat, but one which has been carried out in the last two years at least. Therefore, it behoves everyone to take his tickets now, and not wait until too late.

A meeting of the Physical Society will be held this evening (Saturday) at 8 p.m., in the Wills Library, when various pathological specimens will be shown. It is hoped that there will be a big attendance of men.

We note with much pleasure that Mr. John David Malcolm has been awarded the Liston Victoria Jubilee Prize (value £100) of the Royal College of Surgeons of Edinburgh for his investigation into the causes of shock.

The following letter was received recently from a patient attending Nervous Out-Patients. It seems unfair that one patient should enjoy so many troubles when one considers the numbers whose chief disorder is the absence of a sufficiency of aches and pains:—

7.10.13.

Dear Sir,

I am not sure that you will remember me. the No. of My card is 3. it is 9 weeks tomorrow since I saw you, I have been very ill and had to have a doctor called in. it seems that my inside is wrong besides the diabetes & neuritis and 6 other complaints. you might remember me sir, you always say I look well, I have been under you two years and eleven months (2 years 11 months) but am no better, and I know there is no cure, but the pills ease me, and I hope you will except me as a patient again when this doctor as finished with me. I cannot aford to pay him for long, he is very good and only 3/- a week, (1/6 a visit) I am just geting over a bad atek of Influenza, now I think the Dr. will try and find out what is the matter inside. when we sent for the Dr. I was nearly mad with pain in my head it is better but have some sharp pangs. if I was rich I would ask you to come and see me. these are some of the things I have suffurd in my nearly 54 years, a broken thigh age 1 year, and catarrh from babyhood, at age 6 in a fit for 7 hours from then till 17 falling about by loosing the use of my left side, always pain in back and hip, age 11 had small-pox a fever. came out of hospital one leg longer then the other. went into St. Marys hospital Dr's thought I had hip disease but my mother would not let them operate. Age 16 went in to university Hospital had sinew of the heel cut, all my life sufferd with

ear ach, ulserd throat, legs and feet swellings. Age 20 Dr. told me I had fatty heart, I got married then. My only child born a year after, I was all most helpless for 3 months through extreme weakness, which is one of my troubles, I cannot get strong, always wet with perspiration, in less than 3 years my husband died, age 31 had shock, Dr Hurts says that caused the neuritis, sickness and heart-pains ever since, and loos use of left arm, lots of other things I suffer only it is wasting your time and I am tired. forgive me worring you with this only you always say I look so well and so does every one els. thank you for all your kindness to me I hope I shall see you again.—yours faithfully,

P.S.—Age 45 married again.

Whilst this is the production of a Boro' mother, and was sent with the baby to the Front Surgery :—

pleas docter Chould you see to baby as I have a day work to day Baby is passy green slim and blood as my ysben is Dropet Dead in the hoping ground.

The match against Cambridge University, which is now one of the chief fixtures of Hospital Football, was played on Wednesday, October 22nd, at Honor Oak Park. The game resulted in a defeat for the Hospital by the large margin of 39 points to 8. Owing to the shortness of the time we are obliged to hold over an account of the play to our next issue. Last year Cambridge won by 16 points to 10.

The Appeal for Dental Chairs for the New Conservation Room.

Third List of Subscriptions promised or given to this Fund.

	£	s.	d.
Amount previously acknowledged	324	3	3
*Dr. H. Cameron	15	0	0
*Mr. C. H. Knowles	15	0	0
*Mr. R. J. Gibbings	15	0	0
*Mr. Graham Poock	15	0	0
*Mr. Ronald R. B. Ponder	15	0	0
Mr. G. Owen Betts	5	0	0
Mr. Reginald Umney	5	0	0
Mr. Walter Wilmore	2	2	0
Mr. F. J. Tipper	0	10	6
Mr. C. D. Neale	0	10	6
Mr. S. W. Bevis	0	10	6
Mr. G. H. Aylen	0	10	6
	£413	7	3

The Resurrectionists.

VI.

"*Give me that mattock and the wrenching iron.*"

Romeo and Juliet, V., iii.

The ignorance of authors and of the lay public generally with regard to the working methods of the body-snatchers was shared by the great majority of professional men, not even excepting many of the surgeons who profited by the trade. Here and there a student may have gained an inkling of the way in which the work was done, for the temptation to take part in such thrilling expeditions was irresistible to many of the hospital pupils. For the most part, however, their experience was limited to the unskilled methods of the substitutes employed when the expert gangs were holding aloof from the schools; for the latter were most chary of admitting strangers to a possible knowledge of their professional secrets, and even when a more favoured volunteer was permitted to join them they took care that he should be engaged upon the more trivial duties of the expedition at a distance from the innermost mysteries at the graveside. It frequently happened that the students paid dearly, in more senses than one, for these adventures, for not merely were they cheated and duped on every hand, but they ran in much danger of very rough treatment at the hands of the law besides.

Thus it came about that the wildest speculations were put forward as to the actual modes of exhumation employed. The commonly received idea that the whole of the mound was first removed and the grave re-excavated to bring the coffin to the surface may be at once dismissed; there were more secret and far less tedious ways of attaining the same object. Another theory that found favour with those who in all probability had been intentionally put off the track by an expert resurrection man, assumed the sinking of a narrow shaft at a point beyond the head of the grave in order that one of the workers might descend and detach the woodwork at the extremity of the coffin and so remove the body through this newly-made aperture. For this supposed method the advantage was claimed that, where more than one body had been interred in the same grave, the resurrectionist might help himself from the superimposed coffins at a single operation, as from a series of cupboard shelves. The objections to this theory were, however, insuperable. In the first place, it would have necessitated the sinking of a shaft through unbroken ground beyond the proper limits of the grave, and the original mound would have been appreciably lengthened when the shaft was filled in. Worst of all, it would have involved the task of delivering the greatest width of the body through the narrowest of the dimensions of the coffin; and although to meet this objection the theory was elaborated to

include a process of rounding the shoulders of the cadaver forward upon the thorax, it is difficult to believe that it could have succeeded in practice.

The procedure actually followed by experts was revealed in after years to Bransby Cooper by a resurrectionist with whom he had long been acquainted. The excavation was made in that part alone of the raised mound which was placed above the head of the coffin. It was carried down through the softened earth that had already been broken up at the time of the burial and was therefore to be worked more easily and silently than new ground, and a trick of handling the shovel in gravelly soil was practised by which the noise made by the rattling pebbles upon the iron blade was silenced as much as possible. The shaft was carried down as far as the coffin and a crowbar was next inserted beneath the wooden cover. By applying leverage to the crowbar, the upper third of the coffin lid was lifted until it snapped transversely where the column of untouched earth still pressed upon the coffin at its widest part. The grave-clothes having been removed and returned to the coffin, the body was quickly hauled to the surface and placed in a sack. The earth was then replaced and extraordinary caution was observed in restoring the surface as nearly as possible to its original state; for the experts among the body-snatchers had a wonderful eye for detail, and so careful were they in replacing the occasional flower, or oyster shell, or piece of stick, or oddly-shaped pebble that might conceivably have been placed as a trap by some suspicious friend of the dead man, that times without number sorrowing relations continued their attentions to a grave which had long since been violated.

Only exceptional circumstances warranted the added labour and risk of wholly opening a grave, but this was occasionally done where as consequence of an epidemic or for some other reason several coffins had been interred one above the other within the same grave, for here it was necessary to remove the superjacent coffins bodily to arrive at those beneath. Iron coffins also would have demanded similar treatment, but the ressurectionist was unwilling to concern himself with these, for nothing short of a sledge-hammer would have availed to open them when at length they had been raised to the surface.

It was the risk of discovery and the enormous physical strain involved in these manœuvres that made it so desirable that none but the most speedy methods should be employed, and, in fact, the rapidity with which the exhumations were performed was astounding. In the usual conditions it was considered a good performance to complete the disinterment and restore the grave to its former appearance in three-quarters of an hour; but under the most favouring circumstances—a shallow grave in a loose soil free from stones—a body was occasionally "raised" in no more than a quarter of an hour.

The sack containing the body was usually conveyed from the graveyard in a light spring-cart or hackney-coach that had been kept in waiting if the exhumation had taken place at a little distance from the town; but from the suburbs and the country round about London bodies were often carried in market carts beneath a load of vegetables and were deposited in unoccupied houses on the fringe of the city pending their removal to their final destination next day.

Exhumations were sometimes performed in London graveyards by resurrectionists working independently of the organised gangs, and these men carried their spoil wrapped in a square of green baize to a hiding-place overnight until it was convenient to take it to the dissecting-room; and, as has been said, the dwelling of some student was often selected as its temporary depository.

Bodies raised in the provinces were despatched in packages similar to those in which the ordinary local products and manufactures travelled, and the subjects, therefore, arrived in London in crates and casks under the guise of "Bitter Salts," hats, hardware, and so forth.

Although a considerable supply was maintained at one time from the provinces, yet in later years the tide turned with the rise of medical schools in the great provincial towns, and subjects were then sent from the south-east towards Manchester, Birmingham, Bristol, Exeter, and elsewhere by the London body-snatchers at a time when the public vigilance had made it difficult for them to dispose of their wares at home.

Liverpool, on the other hand, was then comparatively easy to exploit, and bodies were despatched thence in large numbers to Glasgow, Edinburgh, and even London. As happened elsewhere, the depredators at length became reckless, and popular indignation was roused against them, so that for a long time after Liverpool was unable to discover sufficient material even for its own medical schools, and subjects had to be imported from Dublin and London.

Many of the London body-snatchers changed their venue from time to time when they had made their own neighbourhood too hot to hold them. In this way Murphy's rival, Vaughan, after the affair of Holywell Mount, removed for a time to Manchester, and from that place and from Liverpool sent a large supply of subjects to London. After about a year he returned to the south, and, through Murphy's agency, was sent to Maidstone Gaol. After his release at the end of two years he removed to Yarmouth and subsequently to Plymouth, where he was arrested in connection with a body-snatching case that was regarded as a felony rather than a simple misdemeanour, because it was discovered that the rascals had removed certain of the graveclothes along with the bodies. Vaughan was tried and sentenced to transportation for seven years.

Apart from any permanent change of residence, the more skilled resurrection men were frequently commissioned by surgeons to follow up certain of their old cases, and the emissaries hardly ever returned without something tangible to submit to their employer. Neither distance nor expense proved any deterrent to Sir Astley Cooper when he desired to carry out a *post-mortem* examination on a case of any special interest, and the resurrectionists he employed were sometimes sent considerably over a hundred miles on such an errand. His nephew has recorded the details of a bill incurred in 1820 in obtaining a subject of which a country practitioner had informed him and which Sir Astley was determined to secure, "cost what it may." Vaughan and his partner, Holliss, were the men engaged for the purpose, and their expenses for coach-hire, porterage, etc., amounted to nearly as much again as the seven guineas they were paid on account of the body alone. So much reliance did Sir Astley Cooper place on the ability of these men and their willingness to serve him that on one occasion he offered "to procure within three days the body of a dignified official personage who had been buried in a place apparently of impenetrable security."

Liston, the surgeon, when living in Edinburgh, engaged one of the Borough resurrectionists named Ben Crouch to journey to Scotland and assist him in securing the body of a lad who had died of hydrocephalus from a graveyard near the Firth of Forth. A strict watch had been kept over the grave for some weeks, but now, in an unguarded half-hour, the body was raised and the skeleton eventually reached the Edinburgh museum.

Some of the body-snatchers made even longer journeys on errands of their own. When Bransby Cooper was serving with his regiment in the Peninsular War a man presented himself with a brief note of introduction from Sir Astley. On inquiry the man proved to be named Butler, and had come to Spain in search of teeth. "Oh, sir," he exclaimed, "only let there be a battle and there'll be no want of teeth. I'll draw them as fast as the men are knocked down!" And although, naturally, Bransby declined to give him any assistance towards such an object, Butler got back to England with a clear profit of £300. This was the same man who, originally a dissecting-room porter at St. Thomas's, assisted Sir Astley in St. Mary Axe and prepared and articulated the skeleton of the famous elephant. On his return to England, Butler set up in practice as a dentist in Liverpool, but after a while fell away from respectability, and finally was condemned to death for complicity in stopping the Edinburgh Mail. Before the sentence was carried out, however, he was allowed to occupy himself in articulating the bones of a horse. Whilst thus employed he attracted the notice of two Austrian Archdukes who, with some difficulty, procured his pardon on condition that he returned no more to the country.

Two other resurrectionists, Crouch and Harnett, travelled on the Continent from battlefield to battlefield in search of teeth, gold lace from dead officers' uniforms, and anything else that came their way. On one occasion Crouch took refuge in a deserted chatean in the Peninsula, and in pitch darkness started to explore it for any valuables he could find. As he was so engaged he became aware of another person similarly employed. The two robbers were stealthily approaching one another when Crouch, by an extraordinary chance, recognised by the peculiar character of his breathing that his antagonist was his colleague, Harnett, and at once challenged him by name and declared himself at the same time.

By the profits of this expedition Crouch was enabled to set himself up with a large hotel in Margate, but his former occupation becoming known his business fell away, and, in the end, he died in poverty.

R. M. W.

(To be continued.)

Pass List.

Conjoint Board.

SECOND EXAMINATION, SEPTEMBER, 1913.

ANATOMY AND PHYSIOLOGY.

Bowes, E. S.	Neely, W. G. S.
Brogden, I. R. H.	Portway, R. L.
Dowling, G. B.	Tweed, M. B.
Maelzer, N. H. S.	Wacher, H. S.
Morgan, E. C. de M.	Waghorn, L. P.

FIRST EXAMINATION, OCTOBER, 1913.

Part I.—CHEMISTRY.	Part II.—PHYSICS.
*Fasken, N. E.	Laver, B. L.

* Passed in Part I. only.

Part III.—ELEMENTARY BIOLOGY.

Bryant, E. H.	Webster, E. M.

Part IV.—PRACTICAL PHARMACY.

Chevreau, P. R.	Pedley, C. F.
Drew, A. J.	Peregrine, H. L.

Selim, Abd-el-Khalek.

Royal College of Surgeons.

LICENCE IN DENTAL SURGERY.

PRELIMINARY SCIENCE EXAMINATION, OCTOBER, 1913.

Part I.—CHEMISTRY. Part II.—PHYSICS.

*Stiven, F. W.

* Passed in Part II. only.

Midwifery among the Zulus.

The following notes are copied direct from an account given by an old white woman, the widow of a Zulu, of native customs which she had observed while acting as a midwife among Zulu women:—

"A native woman thinks it a disgrace if she is not pregnant two or three months after her marriage. If she does not become pregnant within this period a native doctor is consulted. He demands a beast and gives the woman medicines. Should she become pregnant while using his medicines that doctor is supposed to attend the child if it is sickly after birth. While the woman is pregnant she has to observe certain rules. She must not drink anything hot nor sleep in the daytime, neither must she sit on stone or give way to temper (!). If these rules are broken imprisonment is liable to be inflicted.

When pregnancy has been proved, the woman is provided with a leather apron which reaches from above the breasts to the knees. It is the greatest disgrace to be seen without it. When the woman is eight months gone she has to take various herbs to insure an easy confinement; during this month also she has to plait a long string of grass which is to be used as a binder after delivery.

As soon as labour begins it is reported to the native midwives of the kraal and also to any married women who happen to live near the patient's hut. There are generally at least ten or twelve women attending a confinement.

A strong rope is fastened to the roof of the hut, and the woman in labour squats or kneels upon the floor. A woman sits behind her and supports her during a pain while the patient catches hold of the rope and throws her whole weight upon it. A string is tied around the patient's abdomen and is twisted tight at each pain by the woman sitting behind her; another woman sitting in front kneads and rubs and pushes. If it is a hard and long labour, so much the worse for the poor woman, who is accused of being afraid and of preventing the child's birth. If she cries out during a pain the other women laugh at her and sometimes strike her, comforting her the while with the remark, 'How did your mother give birth to you.'

In some cases of protracted labour the patient is put upon her back and grass ropes are tied to each leg above the knee. The ropes are then passed through the sides of the hut and pulled upon by persons outside while a pain is on. Four or five women at the same time thump and rub and squeeze the patient's abdomen until the child is born. In these cases the injuries received by the mother are generally so severe that further conceptions are rendered impossible. Should the afterbirth be slow in being delivered, the string around the patient's abdomen is twisted tighter and she is also given a calabash or bottle into which she blows as hard as she can; as a rule, this method is effectual. Should this fail, the cord is tied with grass and cut with a thin reed, the maternal end being then tied to the mother's leg. Sometimes the afterbirth has to be dragged away when the previous methods have failed.

As soon as the afterbirth is born, the woman goes down to the river and bathes; if she is flooding she sits in the river until the bleeding stops (!!). She then returns to her hut and the grass binder is wound tightly around her abdomen and is not removed until the cord has shrivelled up and dropped off her child.

The afterbirth is always buried in the hut in which the confinement took place. The women attendants stay in the hut and live with the patient until the child's cord drops off; during this period also the mother has to bathe in the river every day. Her food consists of thin porridge upon the first day; after that the harder and coarser the food the better, for it is supposed to strengthen her. The mother is allowed to drink no milk until the child is three months old.

The child is not allowed to take the breast until it is eight days old, but is fed upon sour milk, which also forms part of its diet after it has started breast feeding. When a native child is born and shows no sign of life, snuff is sprinkled upon its head, and it is also washed in cold water.

The cord is treated in the following manner: a mixture is made of sour milk, soot ,and ashes, into which a sharp thorn is dipped. A number of punctures are then made around the child's navel with this thorn. This process is repeated every three or four hours daily until the cord drops off. No dressing or binder is used for the infant, who is merely covered with an old rug and laid upon the mud floor of the hut.

If the child is ailing or cries very much, enemata are given through a reed, the mother first holding the medicine in her mouth and then blowing it through the reed into the infant who is held upside down during the process.

In all cases of confinement a big fire is made in the hut, which is filled with smoke, the clatter of the midwives, and the groans and cries of the patient. This is a true version of what I have seen with my own eyes many a time and not merely hearsay."

Appointment.

Wilberforce Smith, M.B., B.S., F.R.C.S., Honorary Gynæcologist to the St. Marylebone General Dispensary; also to the Farringdon General Dispensary and Lying-in Charity.

Notes on Spinal Stovaine Anæsthesia.

Thirteen years ago Bier first introduced spinal anæsthesia by using cocaine with results that were far from satisfactory. Some time after this Fourneau discovered stovaine, which was substituted, and is in use at the present day. Until recently spinal anæsthetics were reserved for cases in which for some reason a general anæsthetic was contra-indicated, such reasons being surgical injuries with much shock, acute or chronic lung disease, degenerate arteries with myocardial degeneration, badly functionating kidneys. Their value has been recognised for some considerable time in America and Egypt, and experience has shown them not only to be a valuable adjunct to anæsthetics in general surgery, but to supersede entirely those other means of obtaining analgesia and complete relaxation of musculature in a large number of cases.

In the majority of cases the level of the anæsthesia reaches to an inch or so above the transverse nipple line, that is to say, up to the sixth dorsal segment, and, if necessary, it can be allowed to proceed to the fourth dorsal segment, but here there is a distinct element of danger. The danger with stovaine depends upon the level of the anæsthetic zone; above the nipples the patients usually complain of faintness, they will vomit or suffer from air-hunger from inhibition of the intercostal muscles.

Operations can be performed anywhere in the anæsthetic area, and it is remarkable what complete relaxation of the abdominal wall can be obtained. Age is no contra-indication to this method of anæsthesia; children twelve years old and old men of eighty odd years have been successfully operated on under spinal stovaine.

The technique is very simple: the less apparatus the better. A lumbar puncture needle with a stilette and a "Record" syringe measuring 4 c.c. are all that are necessary, and these are boiled in distilled water. Asepsis is as important in this minor operation as in a major abdominal one. From the patient's point of view it is preferable that the injection of the anæsthetic should be done in bed. The patient is placed on the left side with a small pillow under the loin; the back in the region of the lumbar spines, together with the iliac crests, are painted with iodine. The iliac crests are on a level with the fourth lumbar spine. This is the landmark to aim for, and the needle can then be inserted in the midline passing very slightly upwards either above this, between the third and fourth lumbar vertebræ, or below between the fourth and fifth; the former will be found the easier. When it is felt that the point of the needle is within the dura of the spinal cord, withdraw the stilette and attach the syringe, which has been previously filled with stovaine. There is no need to allow any of the cerebro-spinal fluid to escape apart from that which indicates that the canal has been tapped. Then—and this is an important practical point—draw into the syringe 2 c.c. of the spinal fluid, allow it to mix with the stovaine solution, and inject the mixture slowly. The reason for this last manœuvre is to be quite sure that the solution will be inserted into the right place; if the spinal fluid cannot be drawn into the syringe, even though it has run out easily with the insertion of the needle, it follows that the latter has slipped out of position, the slightest movement in some cases being sufficient to make the difference between success and failure. The needle is then withdrawn and strapping with a small piece of gauze is applied over the puncture. The whole procedure should not take more than two or three minutes. If difficulty is found in insertion of the needle between the laminæ, the space may be increased by approximating the patient's knees and head.

The extent of anæsthesia depends upon the position of the patient. If the legs are to be operated upon, he can be sat up; if only the right or left inguinal region, he should be placed upon the corresponding side for a few minutes before finally resting on the back; if the abdomen is the site of surgical interference, he should lie flat with the head or head and shoulders slightly elevated.

The first signs of anæsthesia are tingling and formication of the toes, loss of plantar, knee, and cremasteric reflexes, and finally complete loss of sensation; the anus becomes insensitive and the sphincter relaxed. Morphia and scopolamine may be given previously as with a general anæsthetic, and if the patient is very nervous at the commencement of the operation a few drops of C.E. mixture can be given with advantage to produce temporary unconsciousness, which will then very easily pass into a natural sleep.

The solution that has been used with success in twenty-one cases consists of the following:—

℞	Stovaine	·04 grm.
	Epirenin Borate ...	·00012 „
	Sodium Chloride ...	·001 „
	Aq. ad.	1 c.c.

The dose for an adult is ·08 grm. stovaine and for an infant ·02 to ·04 grm.

A spinal anæsthetic given in combination with open ether in a long and tedious abdominal operation, for example, Wertheim's hysterectomy, diminishes shock and also the amount of ether that is required. In gastric operations or in those involving the upper abdomen, traction on the peritoneum that is reflected on to the posterior abdominal wall will often temporarily disturb the patient, but not severely enough to cause trouble.

When the patient returns to bed he should be propped up and food can be administered shortly afterwards if there are no contra-indications.

The duration of the anæsthesia for practical purposes is from an hour and a quarter to an hour and a half, but three to four hours elapse before complete sensation is recovered.

It is very interesting to study the question from the patient's point of view. Very few object to this method of anæsthesia for the unpleasant aftermath that so often occurs with chloroform, ether, and their mixtures is absent; whilst generally patients have voluntarily expressed their satisfaction at being helped out of their physical troubles so easily. To please the patient two things are essential: rapid introduction of the solution and perfect anæsthesia. It is very distressing to the victim and onlookers to watch an anæsthetist making futile jabs at the spinal canal, and backache may result later on from inflammatory exudate secondary to the repeated ineffectual attempts to introduce the needle. In the failures either the needle is pushed in too deeply into the intervertebral disc or it is successfully blunted by trying to perforate the vertebra itself.

The question has often been raised as to what damage can be done by the needle not passing direct into the canal, and what damage can be done to the nervous tissue either by the needle or by the stovaine. It will be remembered that the spinal cord in an adult ends at the lower border of the first lumbar vertebra, while the dural sac containing the cauda equina is continued on to the second sacral vertebra. If the middle line is adhered to there is not much risk to the nerves of the cauda equina as they are situated laterally. In children the risk is greater, for here the spinal cord reaches to a lower level—at birth to the level of the second lumbar vertebra. Cases of subsequent paralysis have been reported but rarely, and it is not certain that stovaine is the responsible agent. Trivial headaches are the more common after-events, but these react to aspirin and bromides. It is important to remember that stovaine is decomposed by alkali, that the needle and syringe must not be boiled in an alkaline solution; the ampoules in which the solution is stored must not be made of alkaline glass.

These remarks are by no means meant to be didactic, but merely to show how useful and simple spinal anæsthesia is with a small amount of practice and experience. H. L. J.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the Gazette *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette." Guy's Hospital, London, S.E.*

Society for the Propagation of the Gospel.

Vacant Posts Abroad.

Sir,—I wish to make known to students and junior members of the medical profession some openings which, putting aside other aspects of the work, provide a variety of cases and scope for the performance of important operations greater than commonly fall to the lot of general practitioners in this country. In the majority of these places there can also be the inspiring reflection that there is no other qualified doctor within many miles to whom the patients could possibly apply for the treatment they need. The salaries, except in the case of Rusapi, in Mashonaland, where there is a Government guarantee of £300, besides private practice, are small, but sufficient for comfortable maintenance of unmarried doctors, being the same, both for men and women, as those offered to the clergy working under similar conditions in the S.P.G. missions, in connection with which these posts are.

The doctors must be in full sympathy with mission work, but will not be required to do any but their professional work, unless they desire it themselves. The vacancies are, for men: (1) Hazaribagh, Behar, India; (2) Rusapi, Mashonaland; (3) Kwamagwaza, Zululand. For women: (1) Ping Yin, North China; (2) Delhi, India; (3) Malacca. In all these places the hospitals are in full working order. Several more men are wanted for China and three women for India, but we could not send them at present owing to lack of funds. Our doctors never enter into competition with private practitioners or those working in Government posts.

If you will kindly insert this letter in the forthcoming number of the Guy's Hospital Gazette it may prove an assistance to the efforts which the S.P.G. is now making to meet the great need for medical aid in places otherwise unprovided for by bringing these vacancies to the notice of some who are suited to fill them.

I shall be glad to answer fully any inquiries made from me about these posts and the needs and plans of this department of the S.P.G.

K. W. S. KENNEDY, M.B.,
Secretary, Medical Department, S.P.G.
15, Tufton Street,
Westminster, S.W.

Gazette Special Pathologist.

H.V.M., Clacton-on-Sea.—This specimen contains a little blood-stained muco-pus, but tubercle bacilli are not detected. PATHOLOGIST.

A Case of Lymphatic Leukæmia with Combined Degeneration.

CLINICAL LECTURE BY Dr. HALE WHITE.

Gentlemen,—This woman whom I show before you this afternoon came to the hospital last August, and she told us she had had a pain over the left side of the abdomen since a year ago. We therefore examined the left side of the abdomen to see if we could make out a cause for her pain. In doing so we found there was an enormous enlargement of something on the left side of the abdomen, the area of which enlargement you now see marked in brown. It has a very sharp edge; it extends, as you see, to within about one and a half inches of the umbilicus, and downwards nearly to the crest of the ileum. We wondered what that very large tumour could be. Such a tumour on the left side could hardly be anything other than spleen. And when you feel it, as I am feeling it now, you will detect a distinct notch on its anterior border. So it must, almost of necessity, be an enlarged spleen.

Our next problem was as to what could be the cause of such an enlargement of the spleen. When a spleen is of that size you naturally begin to think of some disease of the blood. There is a disease of the blood, called splenomedullary leukæmia, in which the myelocytes are enormously increased in number, and in which we find a very large spleen, as large as that produced by any cause. Don't have the impression that I mean that the only cause of enlargement of the spleen is a disease of the blood; my point is we think of a blood disease as our first step in the examination. What we found the matter with this patient's blood was not that there were a great many myelocytes but there was an enormous increase in the number of leucocytes, especially of the small ones. When she came in the reds were 4,400,000—not very much less than normal. The whites, on the other hand, were 61,330, or five or six times the normal. The hæmoglobin was 75 per cent. Then we did a differential count of the whites. It was found that the polymorphs were 9 per cent., the small lymphocytes were 89 per cent., the large were 1 per cent., and the eosinophiles were 1 per cent. There was very little the matter with the blood, except that she had a little anæmia, the hæmoglobin is down to 75 per cent., and she had an enormous increase in the small lymphocytes. The number of polymorphs seems very much reduced, but owing to the enormous increase in the total white cells, it works out that the polymorphs are about normal in number. A day or two ago Mr. Ogilvie did another count, that is to say, six weeks after the first, and that shows pretty much the same state of things as the first, for the reds are now 4,680,000, the whites 75,200, and the hæmoglobin is still 75 per cent. The differential white count is as follows: polymorphs, 11·8; small lymphocytes, 87·2; large lymphocytes, 0·8; eosinophiles, 0·8. At once, therefore, we are able to say that what is the matter with her is, that she has the disease known as lymphatic leukæmia.

And now I shall demonstrate some of the other signs which this disease shows. In order that I may do that I will explain to you, as far ae we know, what the disease is. The disease probably lies in the marrow of the bones; they, for some unknown reason, have taken on the multiplication of small lymphocytes to such a degree that you can fairly say this patient is suffering from a small lymphocyte tumour of the blood and of the marrow of the bones. If this woman were transparent and you could see the marrow of her bones, you would see that a good deal of the yellow—the inactive—marrow has become red and active, and that that is true of all the bones where blood is chiefly made. Further, all the marrow is stuffed with small lymphocytes. This leads to an increase of lymphocytes in the blood, which is enormous, and they have to be packed away somewhere. The organ which most easily holds them, which is, so to speak, the reservoir for them, is the spleen. And if she were transparent, and you could use the microscope, you would see the spleen packed with these lymphocytes; they are so numerous that the spleen would seem to consist of very little else. An attempt is being made to destroy them, for phagocytes might be seen eating them up in the spleen.

In this disease frequently the lymphocytes get packed away elsewhere. It would not be necessary in her case, because her spleen is so large. But in some sufferers from this disease the spleen is not capable of dealing with so many of them, and they get packed away in other lymphoid tissues of the body. After the spleen, the next most frequent place for them to be packed away is in the liver. There is an enlargement of the liver here, it extends two fingers' breadths below the ribs as you can see by the broad black line drawn on the abdomen. Probably her liver weighs about one-sixth more than it should. The other parts of the body in which you very often in this disease find these cells packed away are the lymphoid tissues of the body, such as the lymphatic glands, and they are, perhaps, more likely to be packed away there than in the liver. But in this case, as the spleen is so large, and the liver is also enlarged, we do not find evidence that many lymphocytes are tucked away in the lymphatic glands; her tonsils are not enlarged, her axillary glands are just palpable, but you would scarcely call them abnormal. Nevertheless in this disease it is very common for the lymph glands to be enlarged, hence you often find enlarged glands in the axilla, the groin, and the neck. Lymph structures in which you are also likely to find these cells packed away are those in the alimentary tract, because we know what a large amount of lymphoid tissue there is in that tract. I doubt whether this patient's sub-epithelial lymph tissues are much infiltrated in the alimentary tract because her spleen is so big. In the Museum there are some beautiful specimens of infiltration of sub-epithelial tissues of the alimentary tract.

There are other symptoms of the disease which this patient does not show very strikingly, because the other symptoms are largely dependent on the anæmia. Her disease is not advancing very fast, and so might be termed chronic, hence her anæmia is not great. The reason is, that if the case is acute, and the whole function of the marrow is suddenly upset by a great tumour formation of white cells, consequently not many red cells are formed, those which are formed are imperfect, and there is much obvious anæmia. But if the case is chronic, the red cell-forming function of the marrow seems to be able to accommodate itself to the excessive white cells. If a patient is taken acutely ill he is much more upset than by a chronic illness; we see that in the case of acute phthisis in contrast to chronic fibrous phthisis, for in the latter the patient can gradually accustom himself to the altered condition of things. Our patient has had her disease over a year, and her bone marrow has accommodated itself to the altered circumstances. Hence we do not look for many symptoms of anæmia in such a chronic case as this. People with profound anæmia, when this disease is acute, will complain of much shortness of breath, they are pale, and have a temperature of 99° to 100°. Our patient's temperature is normal. In the acute stage with anæmia the pulse is feeble, and there is a liability to hæmorrhages—I need not recapitulate all the symptoms of severe anæmia. Because of the large number of white cells in the blood, there is usually evidence of their destruction in the urine, seen in a large increase of uric acid in it. That is a common feature of many leucocythæmias. But this patient, for a reason I shall mention presently, has incontinence, so that it is difficult to collect her urine properly. In consequence of that we have not been able to make accurate observations in connection with her urine, but Mr. Ryffel has kindly estimated the uric acid and it appears to be increased. The lymph tissue of the kidneys gets packed with these cells occasionally, and so these patients get a little albuminuria. Our patient has none.

It is always interesting to try and link diseases together, because the more diseases you can think of in the same category, the more interesting your study of medicine will become. Two or three years ago I gave a clinical lecture on a kind of disease closely allied to this in a way. The patient was a woman who came with an enlarged spleen, and if her blood had not been examined in a routine way, her real condition would not have been discovered. It was found that she had polycythæmia, that is to say, an enormous increase of red cells.

And it so chanced that at the same time there were two other patients in whom we were able to observe the same condition. The most interesting case was that of a man, and his red cells, as counted under the microscope, were about double the normal number. We sent him up to Oxford, and Dr. Douglas kindly estimated the total volume of the blood for us, and it was found that the total volume of blood was three times the normal, thus the red cells reached the enormous total of six times the normal. His blood had got to that condition of viscosity that it was impossible for it to become much worse and yet be able to circulate through his capillaries. He had a twin disease to that of this woman, because he had a tumour of his red cells, and if we had had an opportunity of examining his marrow, we should have found it very active indeed. His increase of them was so enormous that in order to get them round at all there had to be a great increase in the volume of the blood. You may wonder whether the patient before you has increased volume in her blood in order to get round her increase in white cells. I know of no observations on the volume of the blood in these people, but I should not expect there to be a great increase in her blood volume, because, after all, the white cells occupy but a small part of the blood compared with the red, and there would not be need for much increase in volume to enable seven times the normal number of whites to circulate. However, that is a point which some of you may be able to investigate.

I might remind you that there are other diseases in which the marrow of the bones is affected. The most common is splenomedullary leukæmia in which the marrow goes wrong in respect to another function. Here the myelocytes are formed in the marrow in enormous numbers, and are poured into the blood before they can develop further. And you may find recorded counts of 500,000 myelocytes; and in that condition the spleen is very much enlarged. Until this patient's blood was examined it was impossible to guess even whether she was suffering from myelocytic leukæmia, or from lymphocytic leukæmia, which is what she has got. So there are three remarkable diseases of tumours of the blood originating in the marrow; namely, an increase in the red cells—polycythæmia; (2) an increase of lymphocytes, usually of the small type—lymphatic leukæmia; (3) an increase of myelocytes—myelocytic leukæmia.

There are other diseases of the marrow. One is pernicious anæmia. In it the marrow is incapable of forming proper blood at all; and that is one of the most severe of all these diseases. And there is a very rare condition, known as aplastic leukæmia, in which the marrow undergoes gelatinous degeneration, and the patient has profound anæmia. It is often difficult to diagnose that from pernicious anæmia. And there is a large group of anæmias of children in which there is a deficiency of blood formation in the marrow.

But this woman also came complaining of something very different from anæmia, something which—unless you knew something of medicine—you would not guess she would complain of. She told us that about a month ago she had pains in both her arms, and she noticed weakness of the right leg, and numbness in both legs. In fact, it was the weakness of the legs which determined her coming. It was an extraordinary state of affairs, a nerve disease grafting itself on to a blood disease. And that is really why I have brought her here to-day. In addition to the pains I have mentioned, on enquiring carefully we found she had various other abnormal sensations; she had numbness and tingling down the legs, with "cramps" and "pins and needles." These complaints on her part set us investigating, and it does not matter in what order we take the points in the investigation. The last time of testing she had an admirable extensor jerk of her great toe, and you see she has it still. That is proof positive that she has got organic disease of the nervous system. The same is seen in the other toe. Occasionally we can elicit some clonus in that leg, and the knee jerk is very active. On admission, the Achilles jerk was very marked indeed. What does all this mean? The extensor jerk of the great toe, the clonus, the exaggerated knee and Achilles jerk mean that she has sclerosis of the upper motor

neuron; in other words, she has sclerosis of the lateral columns of her cord. Indeed, the extensor jerk itself in this case would be enough to show that. You will reply—"That is all very well, but what about these peculiar sensory phenomena which she had when she came in? Surely they point to something wrong with the posterior part of the cord." Accordingly we investigated her fully, and we found, as I can demonstrate to you, that she has loss of sensation of every kind except tactile sensation. You see she has no perception of pain when pricked with this pin, she cannot discriminate between heat and cold, as I demonstrate with these test tubes, one containing hot water, the other ice. The prick of a pin she feels as a mere touch. These diagrams show the distribution of these abnormalities. The loss of these sensations extends up on the chest, rather irregularly, nearly as high as the xiphoid cartilage, and it is present, to a slight degree, on the arms. We have already learned that her lateral columns are affected, and we have now further learned that tracts conveying sensations of pain and temperature are also involved. She also has atony of muscles and deficiency of muscle sense, so her posterior columns are involved. She also has loss of control with regard to the urine, and with regard to the fæces too. The remarkable discovery was made a few years ago that you can get this condition of combined degeneration of the tracts of the spinal cord in association with any anæmia, mostly pernicious anæmia. Little dots of degeneration appear in the spinal cord, mostly in the lateral and posterior columns, and they become confluent, and secondary degeneration appears from them, and runs downwards along the lateral columns, and upwards in the posterior. Thus the patient gets considerable sclerosis of lateral columns and posterior columns. Hence, the disease is named combined degeneration. Our present patient's condition must be diagnosed as lymphatic leukæmia, and combined degeneration of the cord. I pass round some slides from a patient who was under me in Mary ward, in which you can easily see the degeneration in the lateral and posterior columns of the spinal cord; the case was one of pernicious anæmia. These degenerations may appear with anæmia of any form, but mostly in pernicious anæmia. I have not previously seen them associated with lymphatic leukæmia, but since the patient came in I have taken the opportunity of looking the matter up, and I find that three other cases have been recorded in which it has occurred. It may occur in the anæmia associated with cancer, in anæmia associated with tubercle, with septicæmia, with ulcerative endocarditis, alcoholism, and syphilis. But it is by far more common in pernicious anæmia. It is a rare condition, and some of you may go a lifetime without seeing another instance. Probably not more than one or two people here will see another instance of it occurring in any disease other than pernicious anæmia. Why it happens, nobody knows. Some say that the anæmia is so profound that little thrombi form in the vessels of the cord, and these lead to patches of degeneration. Others say it is inflammatory. Some say it is toxic. Whenever we do not understand a thing, the usual suggestion is that it is toxic.

To come back to the symptoms of our patient. Is this patient ataxic? The atony of her muscles is so considerable that she can scarcely stand. I am helping her to walk. You notice her ataxy. You see she cannot stand with her eyes shut. These symptoms, of course, depend upon the disease of the posterior columns of the cord. But she has not the lightening pains of tabes, because her posterior nerve roots are not affected. You will ask "why has she got an exaggerated knee jerk, surely it is absent in tabes?" It is exaggerated because her lateral columns are affected too. Disease of the lateral columns exaggerates the knee jerks, disease of the posterior columns reduces it; and it depends on which is in the ascendant whether the knee jerks are increased or diminished. Here the disease in the lateral columns is in the ascendant. Not only do these people not get much pain in the limbs, but, as far as I know, they rarely get crises, for instance, gastric crises, the painful affections so common in tabes. And these patients do not get pupillary symptoms. Her pupils react normally. It is a spinal cord degeneration, chiefly in the lower part. But there is a curious thing

about the anæsthesia which I am unable to explain any more than I can explain why measles appears on the forehead, whereas scarlet fever appears on the chest. I refer to its being of the "stocking and glove" type; the parts chiefly affected are the hand and arm, and the lower parts of the legs.

It is impossible to exaggerate the diagnostic importance of the extensor response in the great toe. For example, the case from which the microscopical slides I have passed round were taken, was sent in under me some two years ago with the diagnosis of anorexia nervosa. We were examining her in the afternoon, and, fortunately, tested her great toe responses, found them to be extensor, and so we knew she could not have anorexia nervosa, which is a functional disease. She looked anæmic, and I asked that her blood should be examined that night. It was found that she had pernicious anæmia. We had the opportunity of examining her cord next day, so if we had not tested the plantar reflex we should have had the mortification of missing the disease altogether. I only tell you that to emphasize the importance of examining the plantar reflex; it is one of the most constant signs of degeneration in the lateral columns of the cord.

The last thing I want to tell you about the symptoms is, that very often the pathologist has an opportunity of demonstrating these changes in the cord when there have been no symptoms complained of during life. I am not surprised at that, for you have to remember that a patient with pernicious anæmia for a few months before the pathologist has anything to do with the case is very ill, and it requires a certain healthiness in order that nerve symptoms may be elicited. If a man were poisoned with opium or with alcohol you would not be able to demonstrate the knee-jerks. The most interesting point is that sometimes the symptoms of combined degeneration appear quite early in the course of the disease, even before the anæmia, so it is said. I do not know why that is.

The patient having been taken away, I have now to tell you that, as far as we know, the disease is uniformly fatal. We tried the effect of giving some salvarsan, which seemed a reasonable thing to do, because arsenic is known to benefit some blood diseases, but the effect of that was for two days to nearly double the number of lymphocytes in the blood; so apparently they are enormously stimulated by that substance. We have not repeated that experiment. X-rays have been tried, but have been found to be no good whatever. So we are compelled to say that the prognosis is extremely gloomy. I have a number of specimens of the blood under these microscopes which you ought to see.

Correspondence.

To the Editor of Guy's Hospital Gazette.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—Ed., G.H.G.]

Fabian Society: Research Department.

Sir,—The Fabian Research Department, in compliance with numerous requests, has started a detailed investigation of the various forms of Industrial Insurance, beginning with the working of the National Health Insurance Act. The investigation will have for its sole purpose to discover what actually is the effect of the Act, and in what way its operation can be improved. Will you permit me to invite Insured persons, Doctors, Nurses, Members of Insurance Committees, Workers in any way connected with Friendly Societies—such as Sick Visitors, Agents, Secretaries, Branch Secretaries, etc., to contribute facts or other information which they think would be of service.

We should, for example, be very pleased to receive copies of the minutes and regulations of Insurance Committees; particulars of societies' admission or refusal; expulsion or transfer of members, or refusal of permission to transfer; adequacy or inadequacy of medical treatment; success and failure of the sanatorium benefit; medical attendance available for persons leaving home, or away from home, the working of the maternity benefit, and so on. We want to hear of every example of satisfaction or success, as well as of every grievance or failure, and to explore all the results that can be yet traced. For this we can rely only on the kind co-operation of the press and the public.—I am,

37, Norfolk Street, Strand, London, W.C. Yours very truly, SIDNEY WEBB.

Pupils' Physical Society.

SESSION, 1913—1914.

The following is the Programme of Meetings for the Session:—

Oct. 11.—Clinical Meeting. President, G. S. Miller.
Oct. 25.—Pathological Meeting. President, O. G. Morgan.
Nov. 8.—Clinical Meeting. President, E. S. Taylor.
Nov. 19.—Paper by Mr. J. H. Ryffel: "The Pathology of Diabetes." President, H. L. James.
Dec. 6.—Discussion: "The Treatment of Syphilis." Major C. E. Pollock, R.A.M.C., will open the discussion. Dr. J. Porter Phillips, Dr. Eyre, and Mr. Thompson will also speak. President, T. I. Bennett.
Dec. 17.—Paper by Mr. A. Sandison. President, J. F. Richards.
Jan. 16.—Pathological Meeting. President, W. E. Tanner.
Jan. 24.—Paper by W. M. Lansdale: "Locomotor Ataxy and other Parasyphilitic Affections." President, E. D. Scott.
Feb. 5.—Address by Dr. C. E. Wheeler (London Homœopathic Hospital) on "Homœopathy." President, R. A. Fawcus.
Feb. 15.—Clinical Meeting. President, A. Wills.
Feb. 28.—Paper by R. W. P. Jackson. President, C. S. L. Roberts.
Mar. 11.—Pathological Meeting. President, J. York Moore.
Mar. 26.—Treasurer's Prize Essay: "Surgical Shock." President and Judge, Mr. F. J. Steward.

The Treasurer's Prize Essay.—Competitors are allowed to treat of any aspect of the subject which they desire. The Essays, which should be written on one side of the paper only, must be sent to the Secretaries on or before February 28th, 1914. They must be endorsed with a pseudonym and accompanied by a sealed envelope endorsed in a similar manner and enclosing the competitor's full name. The name of the winner will be announced by Mr. Steward at the meeting on March 26th, when the successful competitor will be called upon to read the whole or part of his paper.

G. T. MULLALLY,
T. B. HEATON,
Hon. Secs.

The First Meeting of the Session was held in the Clinical Theatre and Wills Library on Saturday, 11th October, Mr. G. S. Miller in the chair. The following clinical cases were shown:—

Congenital extroversion of the bladder at 6 years. Mr. York Moore.
Lymphatic leukæmia with combined sclerosis. Mr. Ogilvie.
Aortic disease with Flint's murmur. Mr. Sampson.
Trachoma and pannus at 8 years old. Mr. Harkness.
Syringomyelia. Mr. Gibson.
Syphilis of the base of the brain. Mr. Liebson.
Cerebral arterial spasm. Mr. H. W. Barber.
Hodgkin's disease.
Congenital syphilis.
Anæmia with eosinophilia.

There was a good attendance of members, and the discussion following the various cases was well up to the average.

Papers by Guy's Men.

Wilberforce Smith, M.B., B.S., F.R.C.S.: Observations on the Condition of the Tissues at the Point of Invasion by Squamous Cell Carcinoma in respect of Altmann's Granules.—*Archives of the Middlesex Hospital. 12th Cancer Report.*

T. B. Layton, M.S., F.R.C.S.: Abnormal Sensations in the Pharynx.—*The Practitioner*, October, 1913.

E. C. Bevers, M.B., B.Ch., F.R.C.S.: Some Conditions which mimic the Acute Abdomen.—*Ibid.*

A. E. Boycott, D.M., B.Sc.: On the Regulation of the Blood Volume in Normal and Nephritic Animals.—*Journ. Path. and Bacter.*, July, 1913.

E. P. Poulton, M.B., B.Ch., and another: On the Variations in the Excretion of Endogenous Uric Acid produced by changes in Diet.—*Quarterly Journ. of Med.*, October, 1913.

W. Johnson, M.D.: The use of Gelatin in Microscopical Technique.—*Lancet*, October 11th, 1913.

R. Denman: Electrargol in Small-pox.—*Brit. Med. Journ.*, October 11th, 1913.

A. C. Jordan, M.D.: A Note on Cardiospasm.—*Ibid.*

A. F. Hertz, M.D.: Suggested Standards in the X-ray Examination of the Alimentary Canal.—*Ibid.*

——The Ileo-cæcal Sphincter.—*Journ. of Physiol.*, October 17th, 1913.

——and another: The Normal Movements of the Colon in Man.—*Ibid.*

E. H. Starling, M.D., F.R.S., and another: The Carbohydrate Metabolism of the Isolated Heart and Lung Preparation.—*Ibid.*

G. N. Meachen, M.D., B.S.: Treatment of Cutaneous Tuberculosis by means of Copper.—*Brit. Med. Journ.*, October 18th, 1913.

W. M. Robson, M.D.: Nocturnal Enuresis.—*Proc. Roy. Soc. Med. Sect. Study Dis. Child.*, July, 1913.

R. Lawford Knaggs, M.D., M.C., F.R.C.S., Retroperitoneal Rupture of the Duodenum.—*Ibid., Surg. Sect.*, July, 1913.

E. Bellingham Smith, M.D.: The Significance of hronic Cough and Wasting in Childhood.—*Clinical Journal*, October 15th, 1913.

Clinical Demonstration from the Children's Out-Patient Department.

The following cases were shown by Dr. Cameron from the Children's Out-Patient Department on Friday, the 17th October, at 12 noon.

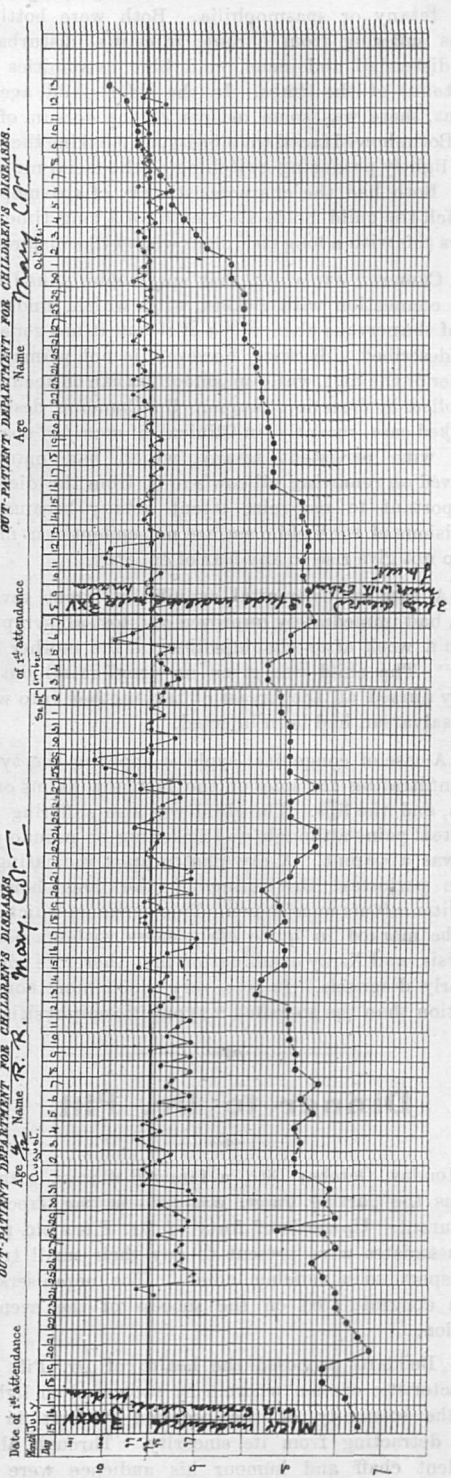
1. Case, aged 2 years, of spastic paraplegia, or Little's Disease, with "scissor" gait and crossed-legged progression. The case was unusual because it also showed a high degree of micro-cephaly.

2. Case, aged 1 year, of severe congenital heart disease with a loud systolic murmur and thrill, with cyanosis and with marked dyspnœa. The case was unusual because it was the second member of the family so affected. Two years ago the elder child, then aged three weeks, had been seen at Out-Patients for severe congenital heart disease, and had died a few days later. A Wassermann reaction will be tried upon the present case.

3. A case of achondroplasia in a boy, aged 1 year, showing the "trident" hand, characteristically shaped head and nose, and shortened limbs. The spinal column showed an unusually well-marked lordosis, and the increased curvature of the sacrum and coccyx and tilting of the pelvis, recently described by Dr. Murk Jansen, was well seen.

4. Cases illustrating alimentary disturbance due to feeding upon an excess of whole milk. The chart of the daily weighing falls and rises irregularly from day to day, and what is gained in one day is lost the next. The temperature is sub-normal and irregular, there is hypotomus of the limbs, distension of the abdominal wall, and very often umbilical or inguinal hernia. On diminishing the amount of milk and on adding the proper amount of sugar, there is rapid improvement in all these symptoms. As shown on the chart below, irregular temperature gives place to the monathermia of the healthy infant, weight rises, and the curve of the daily weighing loses all its irregularities, so that a line drawn with a ruler would pass through almost all the points registered. Dr. Cameron explained that although from the aspect and symptoms of an infant one may suspect that this or that fault in diet is present, proof can only be attained by a chart such as that shown. The infant R.R., for all the clinical examination showed, might have been suffering from tuberculosis, for example, but the chart proves conclusively that it was suffering from lack of sugar in its diet. Even when grossly overfed with milk, infants seldom react with diarrhœa and vomiting. The name which Finkelstein has given to the condition, "weight disturbance," sums up the symptoms.

Two other cases showing a similar condition were demonstrated.



5. Two cases were shown illustrating symptoms of *latent* tetany or spasmophilia. Both were bottle-fed infants suffering from chronic intestinal disturbances with distended abdomens, cold blue extremities and hypertonus of the limbs. In the elder child, aged 14 months, there was some œdema of the dorsum of the feet. Both showed facial irritability, *i.e.*, striking the facial nerve lightly producing twitching of the facial musculature. Both had the characteristic cry of spasmophilia in which the child holds its breath for a long time, and follows this with a long stridulous whoop-like inspiration.

Dr. Cameron explained that spasmophilia had little direct connection with rickets, with which, under the title of the nervous phenomena of rickets it has generally been described. Rickets, however, is not primarily a disorder of the diet, while spasmophilia can be accurately controlled by dietetic changes. Dr. Cameron described a marked case, recently, in Clinical, of *manifest* spasmophilia with persistent tetany, which had markedly improved on removing all cow's milk from the diet. It is important to recognise latent tetany because the convulsions of such children are not epileptic in nature and do not give rise to any fear of epilepsy.

6. A case of congenital syphilis of great severity which had immediately improved and lost all symptoms within a week after the injection of the mother with "606." The child was given no drugs at all but was merely nursed at the breast of the mother into whose veins salvarsan had been injected.

7. A case of congenital syphilis showing the typical rash infiltrating the soles of the feet, the palms of the hands, and the lips. The child was also suffering from periosteal pains although no thickening or pseudo-paralysis was apparent. X-ray photographs indicating the diffuse periosteal thickening of the long bones of syphilitic infants were shown. This periosteal thickening may be marked in quite early cases without pseudo-paralysis, and X-ray examination may therefore confirm an early diagnosis. It is a very much more common condition than the so-called "syphilitic epiphysitis."

Dinner to Dr. Pitt.

On Monday, October 13th, a farewell dinner, with Dr. Pitt as the parting guest, was held at the Trocadero Restaurant. Upwards of forty of Dr. Pitt's old pupils and associates were present to pay their small tribute of respect to a retiring chief. The organisers are to be congratulated on the success of the evening's function.

Dr. Beddard proposed the health of Dr. Pitt in a characteristic oration wherein he succeeded in lightening the solemnity of the occasion without in any sense detracting from its sincerity. Through all his excellent chaff and humour his audience were well able to perceive those strong sentiments of respect and affection which are so universally shared by those who have had the good fortune to work with or under the hospital's newest Consulting Physician.

Dr. Pitt in his reply to the toast, which had been vociferously acclaimed, appropriately adopted a reminiscent vein. His reminiscences, comprising a period remarkable for extraordinary advances in medical and surgical science, were noticeable chiefly for their modest reticence in regard to his own doings, and for the tributes which he paid to his own masters Fagge and Moxon in particular, and to other famous names connected with Guy's.

Farewell banquets are always occasions for some sorrow, but in-so-far as they serve as landmarks in the popularity of the person in question, and afford opportunity for the definite expression of long-felt esteem, they are surely to be commended. Few who were present on this occasion can have felt at all that they had come to bid an unenviable good-bye, and Dr. Pitt's health and enthusiasm were sufficient warrant that he was not in any sense to be really lost to Guy's.

Dental News.

OPENING MEETING OF THE DENTAL SOCIETY.

The First Meeting of the Session was held in Classroom No. 2 on Friday, October 17th, with the new President, Mr. Doubleday, in the chair. The attendance was very good and indicates keenness among the members, and we venture to hope that all who turn up to the tea will also attend the meeting after.

After the minutes of the General Meeting had been read and approved, the President inaugurated the new session by an address. In this he emphasized the benefit that members would obtain by their attendance at these meetings, and he urged all men to do their best to join in the discussion which follows the read-of the paper. He said he was particularly anxious that one paper during the session should be read by a pupil. He also intimated that the "Research Committee" was not extinct, and he was ready to welcome any member who was keen on research work.

Casual communications were presented by Messrs. Underwood, Wright, Bevis, Clewer, and Viljoen.

Mr. Neely then read his paper entitled "Thoughts." It provoked a good deal of mirth, but very little discussion. Among those who spoke were Messrs. Underwood, Laver, and Pitman.

The next meeting will be held on the third Friday in November, when Mr. Clewer will read a paper.

The meeting adjourned at 5.30 p.m.

Yours Sincerely
J. Newton Pitt.

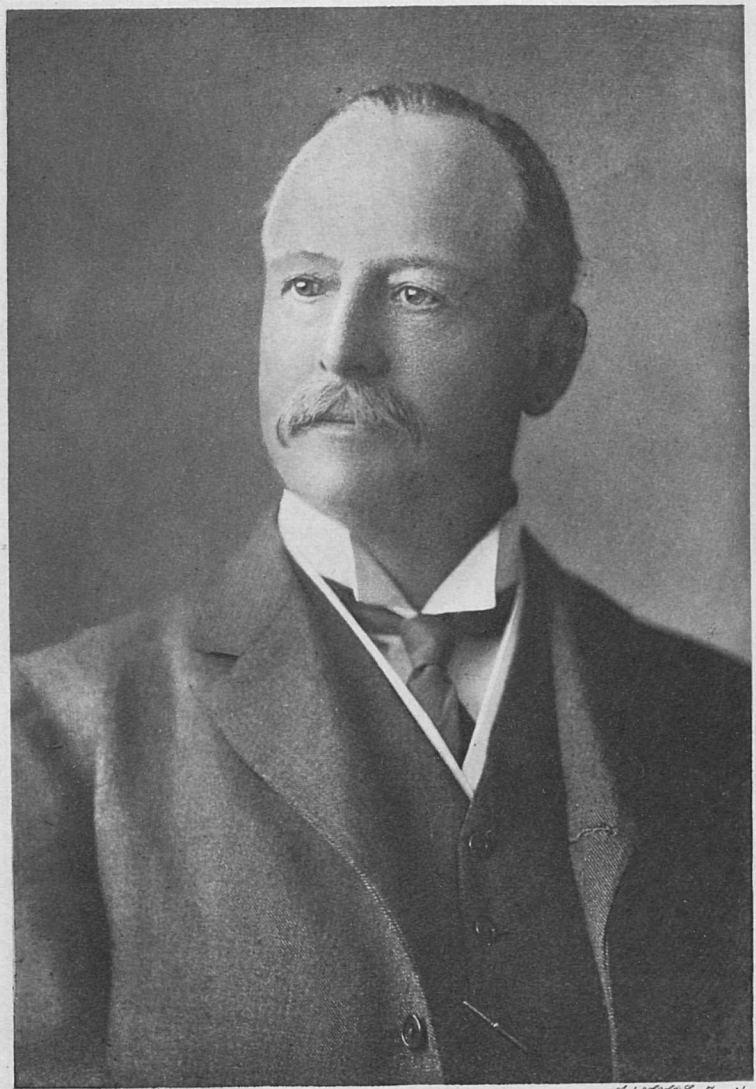


Photo by Swaine, New Bond St. W. Ash & Co. Ld. Southwark.

Yrs Sincerely
G Newton Pitt.

Notices.

Guy's Hospital Ball.

The Guy's Hospital Ball will be held on Friday, Nov. 21st, 1913, at the Prince's Galleries, Piccadilly. Tickets, 12/6, may be had from the Secretaries or the Committee. No money can be refunded unless tickets are returned before November 18th. The Committee reserve to themselves the right to raise the price of tickets after sale of a certain limited number.

Patronesses: Mrs. Cosmo Bonsor and Lady Goschen. Hostess: Lady Perry. Committee: Mrs. Hale White, Mrs. Newton Pitt, Mrs. Fawcett, The Matron, Mrs. Charters Symonds, Lady Fripp, Mrs. Steward.

Joyce's Band. Dancing, 9.30—2.30.

The Proceeds will be given to the Hospital.

W. R. REYNELL,
J. F. VENABLES,
Hon. Secs., Guy's Hospital.

University of Oxford.

EXAMINATIONS FOR THE DEGREE OF BACHELOR OF MEDICINE.

Michaelmas Term, 1913, and Trinity Term, 1914.

The Examinations for the Degree of Bachelor of Medicine will commence in the Examination Schools on Wednesdays, December 3rd, 1913, and June 17th, 1914, Second Examination; and on Thursdays, December 4th, 1913, and June 18th, 1914, First Examination.

Names of Candidates, entered on forms issued for the purpose, must reach the Assistant Registrar, at the University Registry, Old Clarendon Building, Broad Street, not later than 10.30 a.m on Tuesdays, November 18th, 1913, and June 2nd, 1914, accompanied in each case by the Certificates of instruction required to be presented before admission to Examination, and by a Certificate dated and signed by the proper officer of a College or Hall, or the Censor of Non-Collegiate Students, to the effect that the Candidate's name is at that time on the books. The printed Forms of Entry, and all Forms of Certificates, can be had on application at the University Registry.

The Statutable Fee must be paid at the time of entering the name.

On payment of an *additional* fee of Two Guineas, any name not received by the above-mentioned time can be placed in a Supplementary List, and the Candidate be admitted to the Examination, provided that the form, fee, etc., reach the Assistant Registrar, at the University Registry, before 10.30 a.m. on Fridays, November 28th, 1913, and June 12th, 1914.

E. S. CRAIG, Assistant Registrar.

Revision Classes in Medicine.

The Revision Classes in Medicine for the Final Examinations in January, 1914, will commence on Friday, Nov. 7th, with a written paper in the Committee Room, Medical Office, at 10.30 a.m. All who intend presenting themselves in Medicine at the above Examination must attend this test.

Guy's Hospital, Oct. 22nd, 1913.

Royal College of Surgeons of England.

DIPLOMA OF FELLOW.

First Examination.

Notice is hereby given that clause 7 of Section III. of the Regulations has been altered from

"7. Of having attended a course of Practical Physiology during not less than six months at a recognised Medical School"

to the following:—

"7. Of having attended at a recognised Medical School

(*a*) a course of Experimental Physiology.
(*b*) a course of Chemical Physiology,
(*c*) a course of Histology;"

and that this alteration will apply to all Candidates, not Members of the College, who present themselves for the Examination in May, 1914, and for subsequent Examinations. S. FORREST COWELL, Secretary.

FIRST PROFESSIONAL EXAMINATION.

Notice is hereby given that the forthcoming First Professional Examination for the F.R.C.S. will commence on Wednesday, November the 5th, and that future examinations will commence on Wednesday instead of Thursday. FREDERIC G. HALLETT,
Secretary to the Examining Board.

14th October, 1913.

Change of Address.

H. W. Catto, M.B., B.S., from 67, Salford Road, Streatham Hill, S.W., to The Pathological Institute, Kingston, Jamaica.

W. W. Farnfield, M.R.C.S. Eng., L.R.C.P. Lond., from Mere, Wilts, to South Lynn, Gillingham, Dorset.

Dr. C. H. D. Ralph, W.A.M.S., from Winnebah, Gold Coast, to Canford Cliffs, Bournemouth, till February, 1914.

Frank J. Pearce, from 37, Queen Anne Street, to 57a, Wimpole Street, W.

C. Graves Morris, L.D.S., from 32, Lensfield Road, Cambridge, to 17, Beaumont Street, Oxford.

C. D. Killpack, M.B., B.S., from Hammersmith Infirmary to Bromham Road, Bedford.

E. G. Schlesinger, M.B., B.S., from The College, Guy's Hospital, to 15, Upper Gloucester Place, Regent's Park. Telephone, Paddington 991.

Vivian T. P. Webster, from Brynglâs, Merthyr Tydfil, to Ty Gwyn, Merthyr Tydfil.

S. Walshe Owen, 188, Holland Road, Kensington, W.

H. L. Power, L.D.S., 81, Thrale Road, Streatham, S.W., and 270, Earl's Court Road, South Kensington, W.

Harold Chapman, 15, Upper Wimpole Street, W.

Wilberforce Smith, M.B., B.S., F.R.C.S., from 68, Wimpole Street, to 18 Wimpole Street, W.

G. B. Cockrem, Surgeon, R.N., from H.M.S. *Russell*, 4th Battle Squadron, to H.M.S. *Albemarle*, Portsmouth.

(*The Editor will be very glad to receive a postcard with notes of any change of address.*)

A Ballad of Motor Cycling.

Many there are who take a weird delight
In walking all day long behind a ball,
Striking fierce blows to speed it on its flight,
Using bad language at the boundary wall.
They have their pleasures, but they're mixed with gall,
For Colonel Bogey is a constant goad;
We have a joy whose flavour cannot pall—
The open throttle on a country road.

Our motor purrs, we revel in its might,
Life has no cares, no troubles can appal,
Each hour is charming, everything is right,
Save that the hours are short ere twilight fall;
The long white highway writ in devious scrawl
Reads back too soon to our serene abode.
Joys ye may know. All other other joys are small—
The open throttle on a country road.

Do you remember how from morn till night
The hedge slid past us like a waterfall,
Each turn revealed new beauties to our sight
The paths of England's garden, that was all.
The wayside inn—upon some grassy knoll
The peaceful pipe, while down our throats there flowed
Long draughts of beer. How pleasant to recall
The open throttle on a country road.

Prince! you have hirelings at your beck and call,
Your limousine is fitted *à la mode*,
You cannot know the joys that us enthrall.
The open throttle on a country road.

Papers received. — Middlesex Hospital Journal, Hospital, Clinical Journal, Nursing Times, London Hospital Gazette, M.S. Journal.

Reviews, etc.

A Companion to Manuals of Practical Anatomy. By E. B. Jamieson, M.D. (Henry Frowde and Hodder & Stoughton). Price 6s. net.

We have had our "Pocket Gray" in London for a good many years now, so we are in no position to condemn the Edinburgh School for following suit with a "Pocket Cunningham." All the same it is a sad thing to see so much time and energy expended on such arid and sterile work as the production of an anatomical "cram" book must entail. Nor are we in the least convinced of the necessity of the work when all is said and done.

The author in his preface says, "The book is meant to be used as a companion to a dissecting manual for revision of work whilst the dissection of a "part" is in progress. . . But the book may be *used also for revision after the dissection of the body is completed* . . ." The italics are our own. Unfortunately this latter will be the only use to which many misguided men will put it, however much the author may regret the fact. There are unfortunately a number of men so constituted that the size of a book and not its arrangement is the primary consideration. They believe the shortest way to knowledge is both the quickest and the easiest, and so they seize upon these "cram" books and commence eagerly to devour them. They are quickly surfeited with their tabloid learning and shortsightedly condemn, not the book for its indigestibility, but the science they have attempted to bolt. The result is, of course, that they become completely disgusted with their work and lose all heart, and, never having grasped the fundamental principles of their subject, they make half-hearted attempts to cram a few disconnected facts into their heads on the approach of an examination. They do not, of course, assimilate any of them, and as soon as the immediate stimulus is removed, their whole stock of knowledge evaporates in thin air.

Examinations are, under present conditions, a necessary evil. The effect of "cram" books is to unnecessarily accentuate the evil enormously.

The general appearance and arrangement of the book is good, as is the printing, although the type is too small. There are, of course, no illustrations.

The S.P. Pocket Guide Series. (The Scientific Press, Ltd.). Price 1s. each net.

This series aims at providing simple volumes containing the essential points in a subject in a form suitable for ready reference. It is intended mainly for nurses and perhaps students, but it is not a series

of "cram" books. Some of the volumes are excellent and should be very helpful at times.

Bandaging made easy. By M. Hosking. This is a really admirable little book; the illustrations are excellent.

How to write and read Prescriptions. By Lytton Maitland, M.D.

Principal Drugs and their Uses. By a Pharmacist.

Manual and Atlas of Swedish Exercises. By Thomas D. Luke, M.D., F.R.C.S.

The British Red Cross in the Balkans. Published under the auspices of the British Red Cross Society. (Cassell & Co., Ltd.). Price 1s.

This is a collection of over one hundred photographs taken by members of the various Red Cross units who saw service in the Balkan War. The photographs, most of which are very good, are exceptionally interesting and give one a sort of bird's-eye view of the conditions under which the work was carried on.

Other Books Received are:—The Deaf (P. S. King & Son), 6d. net; Earlswood Asylum Annual Report, 1913; Thompson's Compendium of the Pharmacopœias, fourth edition, 5s. net. (Bale, Sons & Danielsson); E. Merck's Annual Report, 1912.

Rugby Football.

GUY'S v. U.C.S. OLD BOYS.

It was very wet for this match on the Hospital Ground at Honor Oak Park, on Saturday, October 11th. The ball was, all through, almost impossible to handle, and as a consequence the scoring was comparatively low. The Old Boys were very light indeed, and could make but little push in the tight. But in the loose they played remarkably well, and were often dangerously near the line. The Hospital men undoubtedly held them at all points, and would have run up a big score if the weather conditions had been a little more favourable for open play. After several attempts at passing had broken down, the ball at length travelled out to Rook, who ran round to the posts for the first try, Medlock kicking an easy goal. Both Medlock and Curle tried to get Steyn going, but it was some time before he had a real chance, and then had the ill-luck to get hemmed in. Broster was next prominent with a very neat pass to Haynes, who had no difficulty in grounding favourably for Medlock to again kick a goal. Just before half-time Broster and Medlock worked a perfect opening for Crook, who had a clear run in, but dropped the pass.

During the first half the Hospital forwards had not been very well together, although two of them, Roberts and Laver, had played brilliantly. The second half was somewhat more evenly contested for twenty minutes. But Medlock started the Hospital attack again. He put in a perfect dribble from half-way to the line, but except for Laver was quite unsupported. No try resulted. Soon, however, the forwards bunched on the line, and in the scramble Kidman got a try. Then came two tries from Steyn, they were both the result of good passing, and speedy appreciation of a decent opening. Broster, on both occasions, saw the chance and quickly worked the ball out to the wing man, whose burst for the line was quite irresistible. Medlock kicked a goal from the last try, and the final score read: Guy's, 3 goals 2 tries (21 points) to nil. Team:—

Guy's.—A. H. Harkness (back); S. S. L. Steyn, C. L. Curle, R. Crook, A. F. Rook (three-quarters); C. H. Medlock, L. R. Broster (halves); C. S. L. Roberts, O. Parry-Jones, A. S. Liebson, C. H. Laver, M. S. Haynes, E. Llarena, G. Kidman, D. M. Whitcombe (forwards).

Remarks.—It was not a day at all for back play, so its no good talking about dropped passes, etc. The forwards must try and get together more. More solid push in the scrums. In the loose, more determined rushing and following up. So much of the following up was left to one or two men which ought not to be, and the man who had the ball at his feet was often badly supported. Practice will overcome all these difficulties, and a great pack will eventually be built up.

GUY'S v. OLD BLUES.

There was a fine crowd at Honor Oak Park for this match on Saturday, October 18th. The ground was hard and a fast game certain. The Old Blues played the seven forward formation and eight backs, and extremely lively these seven were. They started a very fine pace, and just at first they carried all before them. It was their speedy forwards, who handled, tackled, and passed admirably, that kept Guy's on the defensive for the major portion of the first half. Our forwards could not find their game at all. Roberts played well, so did Laver and Parry-Jones. Quite early in the game Pennington got a try for the Blues, and then a forward of the opposing side got clean away from the line out, and ran to Harkness. A neat pass to Pollard enabled that player to walk over the line, Cullen goaling. Weak tackling led to the downfall of the Hospital soon after. Benns and Trethowan got away from the scrum and sent to Inch who very neatly ran inwards for a clever try, Cullen doing the needful. Harris's appearance with lemons gave a welcome breather.

This second half Guy's were a different side, although once or twice they were severely tried by

Dodd. The forwards got the ball out better, but it was so slow that Broster had a very difficult task. "Heave and heel" is what our pack must learn to do. Anyhow, after constant admonitions from Broster to "let him have the ball" they did better. The three-quarters aided by Medlock got going, and then speedily put a different complexion on the game, Curle and Crook getting tries. Steyn had two or three good runs, but he was well marked, and then came a really good try from Medlock which Steyn easily goaled. Splendidly Guy's tried to snatch a victory, but they had not time, no side going with the side playing up very strongly. Final score: Old Blues, 2 goals 1 try, 13 points; Guy's Hospital, 1 goal 2 tries, 11 points. Team:—

Guy's.—A. H. Harkness (back); S. S. L. Steyn, C. L. Curle, R. Crook, A. F. Rook (three-quarters); C. H. Medlock, L. R. Broster (halves); C. S. Lane Roberts, O. Parry-Jones, M. Tweed, A. Liebson, C. H. Laver, E. F. Llarena, G. F. Kidman, D. M. Whitcombe (forwards).

Remarks.—Harkness did very well considering that the centres were missing their men so often. Curle and Crook went too high constantly. Steyn and Rook collared well. The forwards with two exceptions were all going too high. Let each man learn to tackle low and hard; also there must be much more thorough marking at "the line out." The loose rushes are not sufficiently concerted; all eight should go for all they are worth and all together. Broster's passes were not so accurate as usual. The three-quarters stood badly. A straight deep line is better, then each man receives on the run and the wingman at full speed. The three-quarters should be well served as often as possible, but to do this the forwards must heel quickly.

Association Football.

SURREY SENIOR CUP.

GUY'S v. CLAPHAM RAMBLERS.

This game was played on Saturday, October 4th, at Wimbledon on a fairly dry ground. It was the first game of the season and we were not very hopeful as to our chances of success. The game started briskly and kept up a fair pace all through. The forwards of both sides made repeated attacks on the goals, though neither side scored till just before half-time, when H. V. Stebbings beat the goal-keeper with a hard shot from the left.

On resuming, our forwards got away frequently, but shot anywhere but at the goal when they got near it. After several fruitless attempts H. V. Stebbings again scored. Our opponents then brought up their left back to the forward line and made frequent rushes towards our goal, during one of which they scored. We now had most of the game and though our shooting was exceptionally wild (principally owing to the lightness of the ball), M. Pearson managed to score, having had very bad luck in a previous shot where the ball just trickled over the cross-bar. We thus won by 3 goal to 1, so that we now enter the second round in which we are drawn against Carshalton.

The shooting of the forwards leaves a big margin for improvement, although, perhaps, it is rather early in the season to criticise the play. Team:—

Guy's.—F. E. Welton (goal); F. J. Biddle, E. S. Phillips (backs); J. S. Stebbings, D. A. Bevis, L. Gill (halves); C. Williamson, A. C. M. Coxon, H. V. Stebbings, M. Pearson, R. J. Pickett (forwards).

Births.

GARDINER.—On October 13th, at 3, Rotherwick Court, Golder's Green, N.W., to Mr. and Mrs. Harold Gardiner, a son.

JEPHCOTT.—On August 25th, at 12, Upper Northgate Street, Chester, the wife of Dr. C. Jephcott, of a son.

Marriages.

MONRO—MANNING.—On September 20th, 1913, at St. Mary Abbot's, by the Rev. A. R. Harpur Smith, assisted by the Rev. A. E. Morris, Claude Frederick Monro, of Salisbury, Rhodesia, to Violet Helena Manning, of "Kiama," Weybridge, second daughter of the late John Edye Manning, of Sydney, New South Wales, and Mrs. Manning, 11, Abingdon Gardens, Kensington.

SANER—DUNSTER.—On Thursday, September 4th, at St. Mary's Church, Hanwell, W., Francis Donaldson, son of the late John Saner of Hull, to Marjorie, daughter of John Dunster, Esq., of The Laurels, Hanwell, W.

WEBSTER—FITZGERALD.—On September 10th, a St. Peter's, Eaton Square, Vivian T. P. Webster, son of Dr. Webster, of Merthyr, and Mrs. Webster, to Norah Geraldine, daughter of E. G. FitzGerald, Esq., and Mrs. FitzGerald, of London.

Death.

FLEURY.—On September 5th, at Hong Kong, Major C. M. Fleury, R.A.M.C.

G. T. M.

GUY'S HOSPITAL GAZETTE.

VOL. XXVII., No. 662.] NOVEMBER 8, 1913. [SIXPENCE.

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Passim.

IT is with profound regret that we have to chronicle in this issue the death, which took place on Sunday last, of Mr. William Anderson, late Ophthalmic Registrar to the Hospital. That Mr. Anderson's health had not been of the best for some time past was known to most of us, but his death, occurring with such suddenness, must have come as a shock to his many friends at Guy's and elsewhere. His wife has our very deep sympathy in her great bereavement.

Although not educated at Guy's, Mr. Anderson, on his appointment to the post of Ophthalmic Assistant and Registrar in 1906, rapidly identified himself with the interests of the Hospital, and by his excellence as a teacher and his enthusiasm for his particular branch of surgery, soon gained the respect and friendship of those with and for whom he worked. After leaving the Hospital in 1911, Mr. Anderson's interest in the institution remained unabated, and the GAZETTE has had cause to thank him for valuable contributions on ophthalmic subjects.

TWICE lately has the Hospital been honoured by visits from Dr. Bainbridge of the United States, and on each occasion he has been able to afford us evidence of his own skill and of the rapidity of scientific advancement across the Atlantic. His fame in the surgical and gynæcological world is already sufficiently great to render any prefatory remarks superfluous; suffice it to say that his marvellous surgical technique, and his success in experimental surgery and in the application of physiological principles are among his outstanding assets. On the occasion of his first visit Dr. Bainbridge demonstrated the operation, which is associated with his own name, for so-called inoperable carcinoma of the cervix. In this operation he achieves as completely as possible a "lymphatic block," removing the glands from the obturator foramen to the receptaculum chyli, and ligaturing the internal iliac arteries. Later, the primary growth is scraped and treated with acetone, without the usual attendant hæmorrhage. The chief immediate benefits of the operation are cessation of, or great diminution in, the pain, discharge, and hæmorrhage, which, needless to say, are the three most trying symptoms of this terrible condition.

At his second visit Dr. Bainbridge gave a demonstration of his treatment of operative shock by the intraperitoneal administration of oxygen, a method which is one of the most recent and promising, and is well supported by experiment.

In the last issue of the *British Medical Journal*, an account may be found of the tribute

paid by Dr. Bainbridge to Sir Arbuthnot Lane and his work, and his careful personal analysis of the Martha cases is proof of his interest in contemporary surgery in England and at Guy's.

THE secretaries and committee of the Landon Christmas Tea, which is given annually for the benefit of close upon seven hundred Borough children, are already, though probably none too soon, showing signs of activity. We would urge upon all our readers the importance of promptitude in the sending of subscriptions. Within the Hospital itself, the money is collected by numerous volunteers, including the Out-Patient Officers, the Dental House-Surgeons, various members of the Nursing-Staff, and the Student-Demonstrators in the several departments of the Medical School. Their task is not a light one, but it is made far easier by early responses to their requests for contributions. Contributions may also be forwarded to the Secretaries, Messrs. A. Seabrooke and J. A. Ryle, or to the Treasurer, Miss Sheldon.

Unfortunately, it is not possible for all of those who assist the Entertainment financially to witness the results of their generosity, but we can assure them that, were it possible for them to do so, they would get a great deal more than their money's worth of enjoyment. For in many ways the Landon Tea is a really remarkable function, and the amount of happiness concentrated in the Out-Patients' Hall on the eventful day seems almost enough to compensate for all the physical and mental unhappiness which pass through its portals during the rest of the year.

WE publish on another page a letter from a correspondent urging the installation of electric light and other reforms in connection with the Fives-court. His suggestion is, we consider, an admirable one and should find a sufficiency of supporters. The number of squash-racquet enthusiasts is on the increase, and with the advent of the winter season the court is likely to be well patronised; seeing, however, that both for dressers and residents opportunities for playing the game are few until after four or five o'clock, and that by this time in the winter months darkness is already upon us, it would seem that even better use might be made of the court if a system of artificial lighting were established. Some there are even, it would appear, who would be prepared to play after dinner in the evening, and as this is the only means of vigorous exercise available during the winter for those living in College, surely every facility should be given them, if only in the interests of health.

WE are among those (minority though they be) who believe racquets or fives to be even more conducive to physical and spiritual well-being than poker or bridge, but that is by the way. At any rate we would advise the out-door enthusiasts to place their very just demands before the Clubs' Union authorities. We will do all in our power to further their plea.

THE Residents' off-going dinner was held on Friday, October 31st, and was generally voted a most successful function. The evening was as usual enlivened by much good humour and indifferent oratory. Songs were rendered by Messrs. Thompson and Eccles, and with very little persuasion the popular retiring president, Mr. C. A. R. Gatley, was encouraged to give a rendering of an equally popular modern refrain. Mr. T. P. Cole was elected President, and Mr. T. I. Bennett, Vice-President, the swing of the pendulum favouring the physicians on this occasion.

As we go to press we are pleasurably informed that the tickets for the Hospital Ball are selling "like hot cakes" (we think that was the phrase) and that the price is shortly to be raised to one guinea. Our pleasure was somewhat impaired, however, when we heard that the tickets were selling badly among the residents and students. We would ask that section of our readers to remember that it is a Guy's Ball, and that it is their business to see that it is a representative Guy's Ball. Let none be deterred by the fear of being inadequately versed in the mazes of the Tango. We understand that the Staff have not learnt it yet, and that the Sisters and Nurses are finding it quite difficult enough.

A Mahometan Pilgrimage.

To the follower of Mahomet, whether he be Moor or Turk, Malay or Arab, Indian or Chinese, the religious life offers one ambition only—the Mecca pilgrimage. His single-minded devotion, unreasoning and unquestioning, to which the religion of conventional Christendom is but a sorry contrast, finds complete expression in this sacrifice. He may do the pilgrimage two or three times—some elect spirits may achieve it half a dozen times, but once he must do it if it is in any way possible. While Paradise is not absolutely closed to those who fail in this prime religious duty, it is assuredly only for those who perform it. I have lately been ship surgeon on a vessel carrying Malay pilgrims from Singapore to Jeddah—the port of Mecca—and thus have had interest in this service and opportunity of observing it in the fulfilment.

Mecca lies in Arabia some 60 miles inland from the port of Jeddah; it is sanctified, as everyone knows, as the birthplace of Mahomet, the Prophet of God, who lived on earth between the years 571—630 A.D. Mecca was a holy place long before the days of Mahomet. At the time when he was born Arab pilgrims assembled there annually, as they had been assembling for centuries, to perform acts of religious devotion at the shrine of the Sacred Black Image which fell from heaven—presumably a meteorite—and the sacred well where Hagar had found water for Ishmael in the desert. Such a religious centre for devotional pilgrimages was a common bond of union among Oriental peoples. Jerusalem was to the Jews what Mecca was to the nomad and heterogeneous, idolatrous tribes of Arabia. The commercial importance which such a centre naturally attained was the reason that brought the parents of Mahomet, an aristocratic family of high caste, to live in Mecca; and it was there that the earlier part of the Prophet's life was spent.

In the persecution to which his propaganda was at first subjected, Mahomet fled to Medina, some 100 miles distant; and Medina henceforth was the centre of his theocratic rule. Medina now, as the place of his death and the shrine of his tomb, is to good Mahometans second in sanctity only to Mecca, and the complete pilgrimage involves a journey to both. From the date of the Hejira, or Flight to Medina, the Mahometan era takes its commencement. These sacred cities are so far almost unknown to Europeans. A few explorers, at the peril of their lives, have penetrated the mysteries and described their experiences: but religious fanaticism runs so high that the life of a European, if discovered, is not worth a moment's purchase. Even at Jeddah where, as at a port of some commercial importance, most of the European powers keep a Consul, life is by no means secure. Only a few years ago these unfortunate Consuls went out together to such a poor picnic as the resources of the desert offered, aroused the jealous suspicions of some passing Bedouins by a trifling accident, and were all promptly butchered.

The transport of the Malay pilgrims to Arabia is the monopoly of a shipping combine, the Company under whom I was serving being the only British line in a ring which is dominated by the Dutch ownership of Java and Sumatra. The shipping companies do not deal with the pilgrim direct, but with the Arab agent, a man named Azagoff, who has grown fabulously wealthy on the profits of his trade. The pilgrim industry, indeed, is exploited as scientifically, and as profitably, as any commercial process. Azagoff's employés travel constantly through the Malay villages, subsidising Mohammedan priests and sedulously fanning the religious flame among the natives. The pilgrimage is made in the autumn of the year, in the season of the sacred month of Ramadán, during which Mahomet, meditating in the cave of Hira, or, as it is said, while in a post-epileptic trance (to which he was subject), received from Heaven the inspiration of the Koran. During this month the devout Mahometan does not eat between sunrise and sundown, nor may even swallow his saliva, which has to be accordingly expectorated. In Singapore I went out in a friend's motor, and till I understood this, could not appreciate the piety of the chauffeur, who spat out constantly to either side of the car as he went along. The shortage of food and sleep during Ramadán, the hottest month of the year, is very exhausting, and employers of labour are heartily glad when the holy month is over.

The whole of the Mecca pilgrimage for the Malay, with a double voyage, occupies three to four months, increasing to six or more if the pilgrim is rich enough, or devout enough, to visit Medina as well as Mecca. It is an expensive journey, for the shipping companies charge exorbitantly, and, when landed in Arabia, the unfortunate pilgrim is exposed defenceless to the depredations and extortions of the native Bedouins, who fleece him remorselessly. To the Malay, incurably idle by temperament and the easy circumstances of life in the tropics, hard cash is scarce, and few would be able to raise the £80 or £100 which every prospective pilgrim is required to show. The system has accordingly been introduced by the Arab collector's touts, of establishing clubs whereto each member of a village contributes regularly, generally in kind. These amounts are pooled, and an annual lottery decides which is the fortunate family to receive the accumulated whole. Pilgrims do not travel singly; if one goes, the whole family goes.

In the medical inspection previous to embarkation of our party at Singapore I had ventured to reject one poor old man, obviously at death's door. The agent, however, pressed me to take him, for if he was left behind sixteen others would stay behind too. I took him, and he died the same night. Apart from

the fatalistic resignation with which Mahometans accept all kinds of disaster or unhappiness, this poor old fellow was quite glad to die, for death whilst on a pilgrimage is invested with all the odour of sanctity. As a matter of fact, many attain such a distinction, for the privations or hardships of the journey, the intense heat of the sun in the desert, and the appalling insanitation of the holy places, combine to account for a mortality which often reaches 20 per cent. of the whole number.

I was glad that we were taking our pilgrims to Mecca, and not on the return journey; in the latter case, thanks to the overcrowding and want of sanitation at Mecca, and the indiscriminate mixing there of all peoples, nations, and languages, some infectious disease is almost always rife, ophthalmia, cholera, and small-pox being the most common. A system of quarantine is in force, and to some extent effective, but impresses one as being designed more with an eye to making money, and from a truly Oriental endeavour to keep up appearances, than as a whole-hearted attempt to prevent disease.

Our pilgrims were a mixed crowd, drawn from Singapore and the native Malay states, from Java and Sumatra, from Borneo and the South Sea Islands, Macassar and the Celebes. They spoke a variety of languages and dialects, and pure Malay was understood only by few. The night before embarkation they assembled on the quay, a motley crowd in every colour of picturesque clothing, with a long row of bullock waggons piled high with their effects drawn up behing them. Food is not provided by the ship and is prohibitive in price in Arabia, so that most brought with them sufficient to last till their return, chiefly in the form of rice. Dried fish, bananas, and strings of cocoanuts also in plenty, the last to retail in Arabia where they fetch a good price.

The next morning under the eye of the harbour-master, the port medical officer, the Dutch Consul's officer, the Company's agent, the Arab agent, the captain, the chief officer, the purser, and myself, embarkation began, and the prospective Hajis (as they are called after they have done the pilgrimage) filed up the gangway tallied by a picturesque Malay policeman, who shouted out the number of each in a musical monotone. On the ship they were accommodated in the upper 'tween-deck, a space usually occupied by cargo. So much cubic space only is provided, no bunks, no partitions. There was a scramble to secure the best places near the port-holes, each family appropriating a patch of deck and proceeding to define its boundaries against encroachment by piling up boxes or bags of rice all round it. Some attempted to secure privacy by hanging up sheets and rugs, but this we discouraged as interfering with ventilation and making the hold insufferably stuffy. As the families went all together there were no farewells and we were soon all embarked and left Singapore behind, many of them looking for the last time on the lovely green gems of tree-girt islands that surround the approaches to its harbour. That night I was awakened at midnight by the quarter-master to see the poor sick man and found him already dead. He was buried at sea the following daybreak tied up in a sheet with a fire-bar. Soon after I was standing on deck and saw the ugly fin of a large shark hovering round; there was little doubt what it was that had attracted him.

After a day or two's sea-sickness the pilgrims settled down and proved as cheerful and friendly a crowd as we could have wished, very different from the pilgrims from Tangier and Morocco. The captain told me he carried some of them to Jeddah once and spent a fortnight of misery in fear of his life. The children especially were unrestrained and happy; some, indeed, became rather impudent and had to be suppressed. They were always clamouring for cigarettes; even the smallest smoked. I well remember seeing one little boy of five or six with a very big head and no clothes but a bead neckless, swaggering about the deck smoking a big cigar which he had cadged from one of the engineers. We had good weather, and most of the pilgrims slept on deck, which was as well, for the 'tween-decks became insufferably close. During the daytime they sat and wandered about, intensely interested in the operations of the cook and in any painting or ship's work that was going on. Many of them, especially the elder ones, wearing large horn spectacles, spent a lot of time reading the Koran or chanting it aloud in a monotonous drone. Meals also took a lot of time, firewood being found by the ship, and each family cooking for itself in little portable braziers under the shelter of the bulwarks. The children seemed for the most part to act as cooks, save for the rarer and more ceremonious processes, as of plucking a fowl, which were performed in state by the head of the family, the rest looking on. Besides firewood, the only other provision made by the ship was fresh water, and this was served out every morning at daybreak by the purser and the carpenter at the rate of a gallon a head. A gallon does not allow a large margin for washing purposes, and thus an admirable preparation was given for their stay in Arabia, where fresh water is so scarce and expensive that no washing is done at all. Twice a day the chief officer and I went on a round for inspection and to hear complaints, but as neither we nor the Malay interpreter knew much of the Bornese dialects which most of them spoke, we could not do more than listen to the complaints. We learnt the phrase for "sweep up the mess," and this was sufficient for practical purposes.

Six times a day the Mahometan spreads his mat and kneels in prayer with his face towards Mecca; though I must say this was not done as regularly or as elaborately by the pilgrims as I had anticipated. Towards the end of our fortnight crossing the Indian Ocean the pilgrims began to get tired of the open sea,

and there was tremendous excitement when the barren rocky coast of Somaliland came in sight, though to many it must have come as a disappointing contrast with the luxurious vegetation of their native islands.

On the seventeenth day a small open dhow bore down on us and the Jeddah pilot came on board, a magnificent Arab in flowing white robes. Within an hour we had threaded our way among the numerous and dangerous sandbanks with which the shores of the Red Sea are beset, and lay at anchor a mile or more from the shore, opposite the gleaming white houses and flat roofs of Jeddah. It was intensely hot, and we spent half of a long and exhausting day before our passengers were all disembarked, carried off, fifty at a time in large open dhows to the quarantine station, where they spend five days under inspection before being allowed to proceed on the last stage of the arduous and hazardous pilgrimage, from which so many will never return.

In these days the idea of a pilgrimage seems an incongruity and an anachronism—a religious pilgrimage, at all events—for scientific pilgrimages as blind in their way and as superstitious are not unfamiliar. It is easy to see the ludicrous in the brawls and murders which accompany these religious exercises, to wax indignant at those who exploit them for commercial profit, to deplore the ignorance of a faith that believes in their efficacy. One may find much to blame and much to despise in the Mahometan religion, but seeing these men and women, a few out of thousands who year by year through the centuries have flocked to Mecca, at the sacrifice of a lifetime's savings and a very real personal danger, in simple obedience to a moral call, one cannot but feel that here there is also much to praise and much to admire; that here, as in the life of Mahomet himself, in a wild, rough mixture of good and evil, of pure and base, of true and false, can be seen a very human craving for spiritual truth, a very sincere struggle towards a dimly-conceived ideal. In the words of Carlyle, "This religion of Mahomet's is a kind of Christianity, has a genuine element of what is spiritually highest looking through it, not to be hidden by all its imperfections. Above all things it has been a religion heartily believed. These Arabs believe their religion, and try to live by it. No Christians since the early ages, or only, perhaps, the English Puritans in modern times, have ever stood by their Faith as the Moslem do by theirs —believing in it wholly, fronting Time with it, and Eternity with it. This night the watchman on the streets of Cairo when he cries 'Who goes?' will hear from the passenger, along with his answer, 'There is no God but God.' *Allah akbar, Islam*, sounds through the souls, and whole daily existence, of these dusky millions. Zealous missionaries preach it abroad among Malays, black Papuans, brutal idolators, displacing what is worse, nothing that is better or good." In recent times, since Carlyle, Mahometanism has come into conflict, not with paganism, but with Christianity, and this last sentence may require reconsideration or rather a flat contradiction. Mahometanism is now no longer a progressive, but a retrogressive, factor in the religious evolution of the world, but as a type of religious sincerity, however misdirected, it may not even now have wholly lost its value.

T. B. HEATON.

Pass List.

Final Conjoint Examination.

MEDICINE, SURGERY AND MIDWIFERY.

*W. E. Tanner.	*F Cook.

MEDICINE AND SURGERY.

*H. Mather.	*J. Y. Moore.

MEDICINE AND MIDWIFERY.

W. R. Pryn.	C. Sherris.

SURGERY AND MIDWIFERY.

F. C. S. Broome.

MEDICINE ONLY.

F. Tooth.	*A. C. Hancock.
*W. L. Gwyn-Davies.	T. A. Townsend.
*J. L. D. Lewis.	*J. R. Lauder.
*F. V. Bevan-Brown.	C. F. Pedley.

SURGERY ONLY.

*A. S. Erulkar.

MIDWIFERY ONLY.

G. B. Pritchard.	P. R. Boswell.
H. P. Whitworth.	W. D. Galloway.
H. S. Groves.	*C. S. Lane Roberts.
*A. J. E. Smith.	T. R. Trounce.
A. Abd-el-Al.	R. B. Campion.

*Denotes completion of Examination.

Papers by Guy's Men.

Sir W. Arbuthnot Lane, Bart., M.C,, F.R.C.S.: An Address on Chronic Intestinal Stasis.—*British Medical Journal*, November 1st, 1913.

J. Howell, M.B., B.S., F.R.C.S.: A Clinical Study of the Chief Function of the Peritoneum.—*Lancet*, October 25th, 1913.

J. M. Barrionuevo: Estudio sobre la Anquilostomiasis, su Desarrollo en Costa Rica y Leyes dictadas para combatirla. [A Study of the Anchilostomum Duodenale, its Development in Costa Rica, and Laws dictated by the Government to combat it.]—*Archivos del Hospital Rosales* (San Salvador), December No., 1912.

H. T. Binns: Presidential Inaugural Address, delivered at the Annual Meeting of the Northern Counties Branch, Newcastle-on-Tyne, July 12th, 1913.—*British Dental Journal*, October 15th, 1913.

The Resurrectionists.

VII.

"The body-snatchers they have come,
And made a snatch at me;
It's very hard them kind of men
Won't let a body be!"

Mary's Ghost, Hood.

During the period in which the resurrectionists carried on their traffic the sums of money asked, and obtained, for subjects varied considerably. In general from three and a half to five or six guineas was considered a reasonable price, but on occasion values increased enormously. In Rendle's time—about 1830—Guy's was paying from four to seven or eight guineas, but before that prices had ranged as high as from twelve to fourteen; and, under very exceptional circumstances, as much as eighteen or even twenty guineas had been given for a single subject. In the other direction prices elsewhere never ran so low as in Dublin, where bodies could generally be had for five and twenty shillings, and sometimes even for as little as half a sovereign. Somehow bodies were always plentiful in Dublin. These figures relate, of course, to adult bodies; those less than three feet in length were generally sold at so much per inch, and we have already learned from the conversation overheard in the Marlborough Street coffee-house that a florin an inch was the current rate of payment in 1823.

Beside the actual prices paid for the bodies there were the fees already alluded to extorted at the beginning and the close of each term by the leader of the resurrectionists. On the other hand, there was a small perquisite due to the surgeon from his school for preparing the body for dissection; but this "shaving-money," as it was called, to the amount of a crown for every subject doubtless found its way to the pockets of the school servants.

These figures make it sufficiently clear that the resurrectionsts followed a highly lucrative, if dangerous, calling. Murphy, we have seen, was enabled under fortunate circumstances to pocket over £100 for an evening's exertions. Another of his trade, probably Ben Crouch, stated in evidence before the Royal Commission that the largest number of bodies he ever obtained was twenty-three in four nights. On the same occasion another body snatcher deposed that his takings in the two years 1809 and 1810 amounted to 305 adult subjects (bringing in on an average four guineas apiece) and 44 small ones.

The large sums of money these men had thus at their disposal enabled them with the greatest ease to suborn the sextons, watchmen, and other parochial officers with whom they had to deal, and before too much competition arose their money was not too hardly earned nor the risk too great to deter them. Most of them were, naturally, shiftless, gin-sodden ruffians who quickly dissipated their earnings, but those few among them who kept their heads soon became leaders of their gangs, and, when opportunity offered, cautiously raised their demands.

There were other tendencies at work which sometimes led to a rise in price. When the health of the city was good and the death-rate, consequently, low; when special vigilance was exercised over the graveyards; and when bodies were buried in quicklime or in graves deep enough for the coffin to be constantly immersed in watery soil; then the scarcity of subjects made itself felt, and the sums demanded were so high that anatomists hesitated before closing with an offer. The teachers, indeed, were caught between two fires, for, on the other hand, were the students clamouring for more dissecting material and making themselves unpleasant when it was not forthcoming.

Many of the students left England to study their anatomy abroad, and those who, perforce, remained at home held indignation meetings at which they threatened to withdraw *en masse* to the Continent, sent deputations to the school authorities complaining that their own teacher was less efficient in dealing with the difficulty in comparison with the chiefs of other dissecting-rooms, and even alleged that their professor had failed to maintain an adequate supply of material by reason of his want of liberality in treating with the resurrectionists. This last charge was the most unjust of all, for not only had the anatomist frequently to make good from his own pocket the margin between the inflated prices and the amount provided by the students' fees, but still further monetary obligations remained to be met before he could ensure the regular co-operation of the resurrectionists. The body-snatchers had established a claim to the assistance of the surgeon who employed them whenever they were in trouble with the lay authorities and, almost as a matter of right, it was expected that he should make a weekly allowance to the family of the resurrectionist who had incurred a term of imprisonment in the course of his employment. Sir Astley spent some hundreds of pounds in keeping his men out of gaol, or, when that was impossible, in maintaining their wives and children. On a single occasion he paid out as much as £160 to extricate Murphy from the consequences of a professional raid at Yarmouth.

It is not difficult to imagine how strongly these men resented any invasion of their monopoly and its privileges. When from time to time the school authorities sought to throw off the yoke and employed those other ruffians who were only too eager to gain a footing in so remunerative a business, the professionals endeavoured to frustrate the efforts of the "black-legs" by fair means or foul, generally with success. Amongst

the irregulars enlisted at a time when the terms demanded by "the trade" were too preposterous to be conceded were a gang of men, ostensibly Spitalfields weavers, prepared to undertake any knavery that promised a sufficient reward. It sometimes happened that these men were surprised at their work and soundly thrashed by members of the recognised firms who thereupon robbed them of their spoils. Sometimes their plans became known and were betrayed to the police, so that not only was the graveyard kept under observation, but the depredators were occasionally caught in the act of despoiling a grave and sent to prison. The policy of revenge went further: bodies obtained in this illicit fashion were traced to their destination, and as soon as possible the dissecting-room was broken into and the subjects either stolen to be sold elsewhere, or, if too late for that, the body was so mutilated that it was quite useless for further dissection. In one authenticated instance, at least, a resurrectionist made his way into the Borough lodgings of one of Sir Astley's pupils, where, after the fashion of the times, he was dissecting privately, and, threatening to murder the student if he resisted, proceeded to destroy the subject.

Amongst his other tribulations Joshua Brookes had the mortification of seeing the police (acting on information supplied by a revengeful body-snatcher) seize a body that had been duly paid for. It is scarcely surprising that more than one anatomist gave up his school as much from disgust at the enforced association with these scoundrels as from the pecuniary losses in which they involved him.

One or two of the body-snatchers in the constant employment of the Borough Schools, Rendle tells us, "lived in St. Thomas's Tents, about where the Terminus Hotel now is," that is, to-day, near the railway offices in the eastern part of St. Thomas's Street.

In the earlier years of the nineteenth century the only men regularly employed were Butler, Crouch, Harnett, Naples, Holliss, and Vaughan. We have already followed Bill Butler's progress from the dissecting-room of St. Thomas's to the service of an Austrian arch-duke by way of Edinburgh gaol. Ben Crouch was the leader of the band when Mr. South joined the anatomy school at St. Thomas's in 1813; he was the son of the carpenter at Guy's, and was afterwards joined by a younger brother who had originally followed his father's occupation. Ben Crouch resigned his leadership about 1817 to travel on the Continent in search of teeth, accompanied by his friend Jack Harnett, and on their return to England Crouch obtained possession of some of his colleague's money under false pretences and served a twelvemonths' imprisonment in consequence; and eventually he perished miserably in a tavern near Tower Hill.

The younger Crouch stuck to body-snatching as long as the trade lasted, and finally joined the British Legion for service in Spain and was killed in action.

Jack Harnett managed his affairs better than most of his friends, and died leaving nearly £6,000 to his family. An uncle of his, Bill Harnett, also joined the gang. He was much superior to his associates and in high favour with Astley Cooper and Cline. He was very reliable and was averse from holding out for the absurdly high prices that Crouch, whom he cordially disliked, used to demand. He died in St. Thomas's Hospital, and, curiously enough, at the end implored Mr. Green to promise him that his body should not be examined *post-mortem*. His chosen partner, Josh Naples, a former man-o'-war's man, was likewise superior to his colleagues. He continued in the trade until it came to an end, and was thereafter employed in the dissecting-room at St. Thomas's. Naples is to be credited with an ingenious method of removing a small body from a grave. Having gained employment in a burial-ground he would wait until the mourners had left the graveside before commencing his task of filling in the grave. His first movement was then to transfer the body from the coffin to a sack before shovelling the earth back into the grave. At each stage of this process the sack was shifted nearer to the surface, but always with a slight covering of mould until finally the grave was completely filled in, whilst the sack with its contents was easily accessible within the mound as soon as an opportunity occurred to remove it to a tool-shed. The sack, concealed in a nut-basket was afterwards handed on to a confederate. Naples was at length captured with such a parcel in hand, and when on inquiry the graves that had been under his charge were found to have been emptied, he was sentenced to two years' imprisonment. Thence he contrived to escape, but, being betrayed by Crouch, was sent back to complete his sentence. Naples was more frequently imprisoned than any other of his kind, and always on information supplied by one of his rivals.

Holliss and Vaughan we have already referred to in connection with the Holywell Mount affair, and the adventures of the latter at Plymouth which ended in his transportation. Holliss, an ex-sexton, was at length concerned in horse-stealing in a large way, and had the distinction of being one of the last to be condemned to death for that offence, and was duly hanged at the Horsemonger Lane Gaol.

Another dissecting-room attendant from St. Thomas's who joined the band was named Millard. For a long time he enjoyed the best of reputations and was universally popular. At length it was discovered that for some time he had received bodies supplied in all good faith by Murphy, and despatched them, at an advanced price, to Edinburgh. For this fraud he found himself instantly dismissed, and relying on his continued popularity with the students, set up an eating-house in the Borough. The public, however, was rather upset when it learned that he still maintained his connection with the body-snatching traffic along with his other

occupation, and his custom fell away and the business was ruined.

Thereafter he devoted himself to body-snatching alone, but being concerned with Murphy's partner, "Patrick," in a raid on a graveyard attached to the London Hospital, they were captured and committed to prison for three months. Millard, through some influential friends obtained a remission of sentence, but, having regained his liberty, was ill-advised enough to take proceedings against the magistrate for false imprisonment. His case failed and he was sent back to complete his sentence, where, after he had vainly petitioned Sir Astley Cooper to procure his release, his mind gave way and he died raving. His wife afterwards published a foolish pamphlet reviling Sir Astley for having failed to release her husband and for omitting to settle a pension on herself.

The man referred to as "Patrick" was at one time concerned in an unpleasant adventure. Carrying a parcel of bones towards Mr. Grainger's school in Webb Street, he was recognised by a couple of men who followed him with the intention of denouncing him publicly. Near the school he made a dash for cover pursued by the men crying "Stop thief." Patrick succeeded in entering the yard, but failed to close the door against the large mob that had now assembled outside. With the assistance of one other man and armed with a large pitchfork "Patrick" kept the crowd at bay until Mr. Grainger was able to procure a body of constables from the Town Hall to raise the siege.

But of all the dramatic incidents that happened in connection with this gruesome traffic, nothing—and certainly nothing invented by the novelists—compares with the student's discovery in the dissecting-room of St. Thomas's of the body of his sister's little seven-year-old child who had recently died of scrofula. The authorities pacified him as best they could, and the child's body was re-interred in the hospital graveyard.

R. M. W.

(To be continued.)

Appointments.

I.M.S.

Captain James H. Horton, D.S.O., to be Major (dated July 29th, 1913).

Civil.

P. D. Hunter, to be Senior Assistant Medical Officer, Three Counties Asylum, near Hitchin.

A. Read Wilson, D.M., B.Ch., has been appointed to the Honorary Staff of the Blandford Cottage Hospital.

Vivian T. P. Webster to the Staff of the Merthyr General Hospital.

Obituary.

WILLIAM ANDERSON,
M.A. M.B., B.Ch.

WILLIAM ANDERSON was not a Guy's man; he was educated at the University of Aberdeen, and took the degree of M.B., B.Ch. in 1901, and subsequently studied at St. Bartholomew's Hospital and in Berlin. He was House-Surgeon at the Royal London Ophthalmic Hospital, and when on the retirement of Mr. Higgens in 1907 the Ophthalmic Department at Guy's was reorganized, he was appointed Chief Clinical Assistant and Ophthalmic Registrar to Mr. Eason.

He held this post until 1912, and throughout its tenure was very popular both with his colleagues and with the students. Like many Scots, he had a power of lucid expression, and was a very clear-headed and effective teacher, an accurate observer, and a good and careful operator. Notwithstanding his rather frail health—for he had suffered from valvular disease for some years—he was extremely regular in his attendance at the hospital, and was a devoted and untiring worker. The patients were extremely fond of him, and his relations with the staff and with the nurses were of the most cordial character.

Owing to the exigencies of his appointment, and to the fact that for a long time he was working for the Fellowship of the Royal College of Surgeons, he had not much time for research or for writing, but in 1907 he published some articles on the Treatment of Conjunctivitis in *The Hospital*, and contributed other unsigned articles to medical journals. His untimely death has come as a great shock to many of his old friends in the Ophthalmic Department at Guy's Hospital.

Change of Address.

J. H. Mayston, from 17, Mayford Road, Balham, S.W., to 164, Upper Clapton Road, N.E.

C. R. Howard, M.D., B.C., from Selston, Notts., to Garston, Frome.

P. D. Hunter, from East Sussex County Asylum, to Three Counties Asylum, near Hitchin.

A. Read Wilson, D.M., B.Ch., from Bexhill-on-Sea to Eagle House, Blandford, Dorset.

Harry J. Hoby, M.R.C.S., 7, Magdalen Road, Norwich.

A. M. Bodkin, from The Limes, Kelvedon, Essex, to Trevelyan House, Tiptree, Essex.

C. Worster-Drought, 5, Richmond Place, Hereford.

Maurice Mottram, Sibford Ferris, Banbury.

A. S. Morton Palmer, from 96, Marine Parade, Worthing, to 103, Marine Parade, Worthing.

E. F. H. Hardenberg, from Duffield House, Upton Road, Watford, to Burvale, Rickmansworth Road, Watford.

J. Wallace Kemp, M.R.C.S., L.R.C.P., from Guy's Hospital to 40, Vereker Road, West Kensington, S.W.

T. E. Henderson, L.D.S., to 219, King's Road, Reading, and 29, Hart Street, Henley-on-Thames.

Nasal Discharge.

CLINICAL LECTURE BY W. M. MOLLISON.

GENTLEMEN,—In choosing this subject for my lecture I do not propose to enter into the minute differential diagnosis of various nasal discharges, but rather to put before you some of the more common causes of discharge, to guide you when you are confronted with a case.

I have taken the nature of the discharge as the ground for division of the cases, and suggest the following four groups:—

A. *Mucous*, watery, non-inflammatory, *rhinorrhœa.*

Nasal neuroses.—Paroxysmal sneezing, posture obstruction, hay fever, hypertrophic rhinitis.

Polypi.

Cerebro-spinal rhinorrhœa.

B. *Muco-purulent* or inflammatory.

1. Rhinitis
   - (a) *acute catarrhal.*
   - (b) *chronic catarrhal.*
   - (c) *membranous.*
     - *—diphtheritic.*
     - *—pneumococcal.*
   - (d) *atrophic.*
2. Trauma.—After operations, foreign bodies, rhinolith.
3. Ulcerations.—Traumatic, lupus, syphilitic.
4. Neoplasm.
5. From nasopharynx, adenoids.

C. *Purulent.*—1. Sinus suppuration. 2. Abscess caused by carious incisor teeth.

D. *Bloody.*—Epistaxis, hæmorrhage from polypi or neoplasm.

A. *Watery or mucous discharge.*—We have all noticed that physiologically the nose secretes a certain amount of watery fluid; for instance when we pass from a warm atmosphere into a cold one, particularly when the difference in temperature is great, as in winter. When this secretion is excited abnormally easily it may be said to be pathological, and is then given the name rhinorrhœa. It is not only differences in temperature that excite the secretion, but various intra-nasal conditions, particularly in the neighbourhood of the middle turbinals and septum. Conditions such as hay fever and asthma are extreme examples in which excessive secretion occurs.

Between the physiological secretion and the profuse secretion in hay fever there is a series of conditions, with varying amounts of secretion and other symptoms, sneezing, nasal obstruction when lying down, and nasal irritation. All these conditions are often grouped under one heading and called nasal neuroses to indicate that though the nose is often found to be the determining cause there is some underlying condition—a neurosis—without which the particular condition discoverable in the nose would produce no train of symptoms.

Perhaps many of these cases of rhinorrhœa have a vascular origin; certainly the rapidity of the onset of the symptoms would lend itself to that view; thus, in cases where a patient complains of nasal obstruction alternating from one side to the other, accompanied by watery discharge, the swelling of the mucous membrane of the inferior turbinals may take place in a few minutes while the patient is under examination.

The part of the nose which seems to be most concerned in these nasal neuroses is the mucous membrane of the septum, especially the part of the septum opposite the middle turbinate bones; any pressure here seems particularly apt to set up obstruction and irritation and to lead to rhinorrhœa. The following two cases illustrate this point well:—

Mrs. N., aged 40, was sent to see me on account of watery discharge from the nose; she stated that whenever she went out of doors her nose ran profusely, she had constant attacks of sneezing and could not breathe properly through the nose, the right side being worse than the left; many forms of treatment had been tried without success, amongst them sun baths; under this last she had been much worse. Four years before, an operation had been performed on the septum for some obstruction and since then the symptoms had all appeared. On examination the septum was found adherent to both middle turbinals by a broadish band of firm mucous membrane. These adhesions were divided under an anæsthetic and found to be more extensive than the preliminary examination revealed; since the operation all the symptoms have disappeared.

The second case was one of hay fever.

Miss N., aged 24, complained of profuse watery discharge from the nose, irritation, and obstruction, especially in the early summer. She had enlarged inferior turbinals, and the septum was deflected, though not markedly so. An operation was performed and the anterior ends of the inferior turbinals were removed; this brought about no improvement. A submucous resection of the septum was then carried out and since this second operation all symptoms have disappeared.

In this case though the inferior turbinals appeared to be causing obstruction the real cause of the symptoms seemed to lie in the deflection of the septum and its consequent pressure on the middle turbinal.

Sometimes there is not a deflection of the septum leading to pressure between it and the middle turbinal, but local projections from the septum called spurs; these spurs occur either on the anterior and lower part of the septum and may in that case press against the inferior turbinal or on the posterior part—vomerine spurs—and press on the posterior part of the inferior turbinal or middle turbinal; in either position these spurs may be the cause of a rhinorrhœa and their removal can bring about relief from the symptoms.

There is yet another cause of rhinorrhœa, and that is the presence of polypi; most polypi arise in connection with suppuration in the sinuses about the nose, so that it is more usual for them to produce a muco-purulent discharge, but some polypi seem to have no suppuration accompanying them.

A condition which may be confused with the rhinorrhœa we have spoken of is *cerebro-spinal rhinorrhœa;* in this unusual disease there is an occasional profuse discharge of clear cerebro-spinal fluid from the nose, but it is to be distinguished from rhinorrhœa by one or two points; the discharge is preceded by headache and malaise which is quite cured when the discharge starts, and it is not accompanied by nasal obstruction; in rhinorrhœa of nasal origin the headache and malaise come on at the time the discharge begins, and cease when it ceases; further, the examination of the fluid will lead to a diagnosis, the rhinorrhœa fluid contains mucus and is viscid, the cerebro-spinal fluid has its usual characteristic of reducing Fehling's solution, and contains no mucus.

B. *Muco-purulent :—Inflammatory discharge.* 1.—In all the cases where the discharge is muco-purulent some infection has occurred, though it is not always possible to say what that infection is. All the resulting conditions are various forms of rhinitis, and of these the common cold or *acute catarrhal rhinitis* takes first place, the organism concerned being the micrococcus catarrhalis; the nature of the discharge varies with the progress of the cold, at first watery, soon muco-purulent, and later thicker and almost purulent; on examination the mucous membrane of the septum and turbinals is red and very sensitive, and there is a greater or lesser degree of obstruction to nasal respiration; it is not necessary here to discuss the treatment, except to say that local applications to the nose are contra indicated, but inhalations of eucalyptus oil and menthol are pleasant and relieve the obstructed sensation to a certain extent. Acute catarrhal rhinitis in its late stages may give rise to thick yellow muco-purulent discharge; on examination of the nose in these cases the mucous-membrane is seen to be rather red, and that over the inferior turbinals may be swollen; strands of mucus, too, are often seen passing between the septum and turbinals, and indeed the condition passes insensibly to that of *chronic catarrhal rhinitis.* The treatment of this condition consists, in the first place in the use of an alkaline spray to wash away the sticky mucus; should this prove ineffective, painting the mucous-membrane with a 5 per cent. or 10 per cent. solution of argyrol may be resorted to, in other cases cauterization of the anterior ends of the inferior turbinals will be required. I have seen this simple treatment give complete relief in a case where an obstinate chronic rhinitis was left after an attact of scarlet fever, which had defied all other measures.

Another form of chronic rhinitis is membranous rhinitis; in these cases the organism may be the diphtheria bacillus or the pneumocoocus. The mucous membrane of the nose is attacked by *diphtheria,* as is any other part of the upper respiratory tract; this gives rise to a membrane of a greyish-white colour on the septum or turbinals, and a discharge from the nose which rapidly excoriates the upper lip. One should always suspect the disease in children who have a nasal catarrh of one or two weeks' standing, and excoriation of the upper lip (especially if unilateral), and who look ill and feel ill. The diagnosis of the disease lies finally in the bacterial findings, and the treatment follows that for diptheria elsewhere.

Pneumococcal infection sometimes attacks the nose and gives rise to a membrane not so definite as that of diphtheria, but, nevertheless, a membrane, the removal of which leaves a slightly bleeding surface; the diagnosis here too, will rest with the findings on cultivation. One case seen fairly recently in a nurse, cleared up quite soon with an autogenous vaccine where other treatment had failed.

Atrophic rhinitis is too large a subject to go into here; suffice it to say that the discharge from the nose is mostly in the form of crusts of a greenish or yellow colour, having a most offensive smell. The disease often begins in childhood and is very chronic, and the patients lose the sense of smell early in the course of the disease; the nose is much more roomy than

normal and there is atrophy of the turbinate bones, especially the inferior. A certain proportion of the cases result from suppuration in one or more of the accessory sinuses. The treatment consists essentially in syringing the nose with alkaline lotion containing some deodorant such as carbolic acid, in order to prevent the crust formation.

2. *Trauma.*—Discharge of traumatic origin is found after any operation on, or even manipulation of, the nasal mucous membrane which is extremely sensitive. Often after a submucous resection of the nasal septum a whitish membranous scab is found on the small incision made in the mucous membrane, and invariably after any operation there is some discharge for a few days.

Foreign bodies are almost invariably found in the noses of children and give rise to a considerable muco-purulent discharge. Since the foreign body is introduced almost invariably into one side only the discharge is unilateral; and, indeed, a unilateral nasal discharge in a child is practically diagnostic of a foreign body excluding only the unusual unilateral nasal diphtheria.

3. *Ulcerations.*—The septum is usually the site of ulcerations, though the turbinals may be attacked; they almost always give rise to some discharge because crusts form on the raw edges of the ulcers and come away at intervals.

Traumatic ulcers are found on the septum just inside the nostril, and are made by the patient's nail scratching some irritating spot; this leads to bleeding: the bleeding stops and the clot formed gives rise to irritation, which in its turn leads to scratching; this damages the mucous membrane and after the cycle has been repeated a number of times an ulcer is formed. The treatment of this condition consists in the application of some ointment such as equal parts of ung. hydrarg. oxid. flav. and vaseline.

Lupus attacks the nose and leads to ulceration of the cartilaginous septum or the inferior turbinals.

Syphilis, in the form of gummatous ulceration, attacks the septum, especially the bony septum and the outer wall, and leads to destruction of the bone and formation of sequestra; the discharge in these cases is characterised by its highly offensive smell, and by the fact that crusts are ejected much like those of atrophic rhinitis.

4. *Neoplasmata.*—Arising in the nose itself or invading it from surrounding parts, will give rise to muco-purulent and blood-stained discharge.

5. *From nasopharynx.*—In children, this is the most frequent cause of nasal discharge; perhaps it should have been included under the heading of chronic rhinitis, since it is doubtless by producing a rhinitis that *adenoids* give rise to nasal discharge. Not only do adenoids give a muco-purulent discharge, but they are a most frequent cause of nose bleeding in children, too. Though adenoids are found in children, they occur also later in life, often between 20 and 30, sometimes after 30, and occasionally after 40.

C. *Purulent discharge.*—Almost always discharge of pus from the nose means suppuration in one or more of the accessory nasal sinuses. The diagnosis of this condition is beyond the scope of this lecture and the treatment varies with the particular sinus that is affected.

One other condition which should be borne in mind is that of an abscess in the floor of the nose due to an incisor tooth; when this abscess points in the nose it will give rise to a purulent discharge from the nose: the position of such an abscess is in the most anterior part of the floor of the nose.

D. *Bloody.*—Bleeding from the nose or epistaxis may be due to a general oozing from the mucous membrane, or to the rupture of a branch of a small vessel which lies on the septum opposite the anterior end of the inferior turbinal.

When some general pathological condition of the vascular system is present such as arteriosclerosis, or some form of primary anæmia, or some organic cardiac lesion, the treatment of the hæmorrhage obviously lies with the physician.

Should the vessel on the septum be the source of the bleeding, treatment consists in the cauterisation of the mucous membrane round the bleeding spot after the application of a solution of cocaine and adrenalin.

A Remarkable Case.

Perhaps the enclosed statement of a very interesting and puzzling case by reason of the difficult points of exclusion, may be of some value to your readers. It is one simulating an *Acute Pellagra* (if there be such a disease) or *Pityriasis Rubra vel Dermatitis Exfoliativa*. The history of the case is as follows:—

X. Y., a youth of 21, healthy, went up for the Territorial training in June last, at or near Bridlington, Yorks. He is a clerk in the Newcastle-on Tyne P.O. On September 8th he came to see me complaining of headache, anorexia, constipation, and intense languor; this looked rather suspicious of ambulatory or para-typhoid. There was an indistinct papular or erythematous rash, brick-red in colour, over the extensor surfaces of the forearms, hands, face, and neck (sun exposed parts). There was no intense itching, excepting about pubes and thighs (inner), the reason for this being due to pedicu-

losis pubis, for which he had applied ungt. hyd. fort. rather vigorously. Of course, I suspected syphilis. He had oral sepsis, foul tongue.

On September 17th he came in with a diffuse general rash, papular or erythematous (dermatitis) with desquamation. No throat symptoms, but he looked very ill. Temperature 102°, pulse 80, respiration 20. He was sent to bed. The rash soon became vesicular and afterwards pustular; the desquamation became very copious, handfuls in the bed and on floor. Hæmaturia slight followed, possibly (?) due to urotropine and sod. acid phosph.

The desquamation continued up to date, October 29th; the skin meanwhile peeled off solid from palms and soles.

Now neuritis set in, with twichings and trembling, particularly of the upper extremities, rendering it difficult to count the pulse. No vomiting, no pressure signs in right iliac region. A bed sore formed which soon yielded to treatment, showing vitality. Urine—Sp. gr. 1020. No albumen or sugar. B. coli present, indicated (in the absence of pus or mucus before the hæmaturia) by boiling with liq. potassæ, giving a flocculent appearance.

On October 1st this was confirmed by a microscopical examination of the urine by Dr. Slade, the Bacteriologist of Newcastle-on-Tyne Infirmary, who also found B. staphylococcus aureus—yeasts. Now septic foci occurred all over the body *pari passu*, pus (foul) exuded from the shins, nates, groins, glands of axillæ, and inguinal regions, cellulitis (septic). A Grubber Widal reaction was taken on September 23rd by Professor H. J. Hutchens, M.D., D.S.O., of the College of Medicine, Newcastle-on-Tyne, who reported "negative," no agglutination.

On October 10th, Dr. H. J. Hutchens examined the urine microscopically and reported, B. coli and B. staphylococcus, no pus cells. Soon patient became emaciated, but luckily and pluckily took everything given to him, was rational and cheerful, excepting on the rise of temperature to 105°; then, of course, he was delirious. He was very costive throughout.

On September 29th, Dr. Kerr, the M. O. H. for Newcastle, very kindly saw patient, but did not consider he had either typhus or enterica.

On October 5th to complicate still further this complex case, there appeared dirty white patches upon the fauces and tonsils with stomatitis. A swab was taken and sent to Dr. Hutchens who reported for B. Hofmanni negatively. Nothing but B. staphylococci, yeasts. Bed sore healed; this vitality appeared opposed to syphilis. I excluded that. Reflexes about normal.

October 18th. Much same condition. Red brick pigmentation of arms and face and chest (was it due to the desquamation and dermatitis, and partly to ointment?). It must be remembered that all along the profuse desquamation obscured everything.

Treatment.—Oral antiseptics, calomel, cascara. Stimulants, blood ʒss, port wine ʒss, t.d.s. Lysol and boracic washings and appliances. Lotio carbonis detergens with calamin. Ungt. zinci ox, vasel. and ungt. ichthyol. Sapo. ichthyoli.

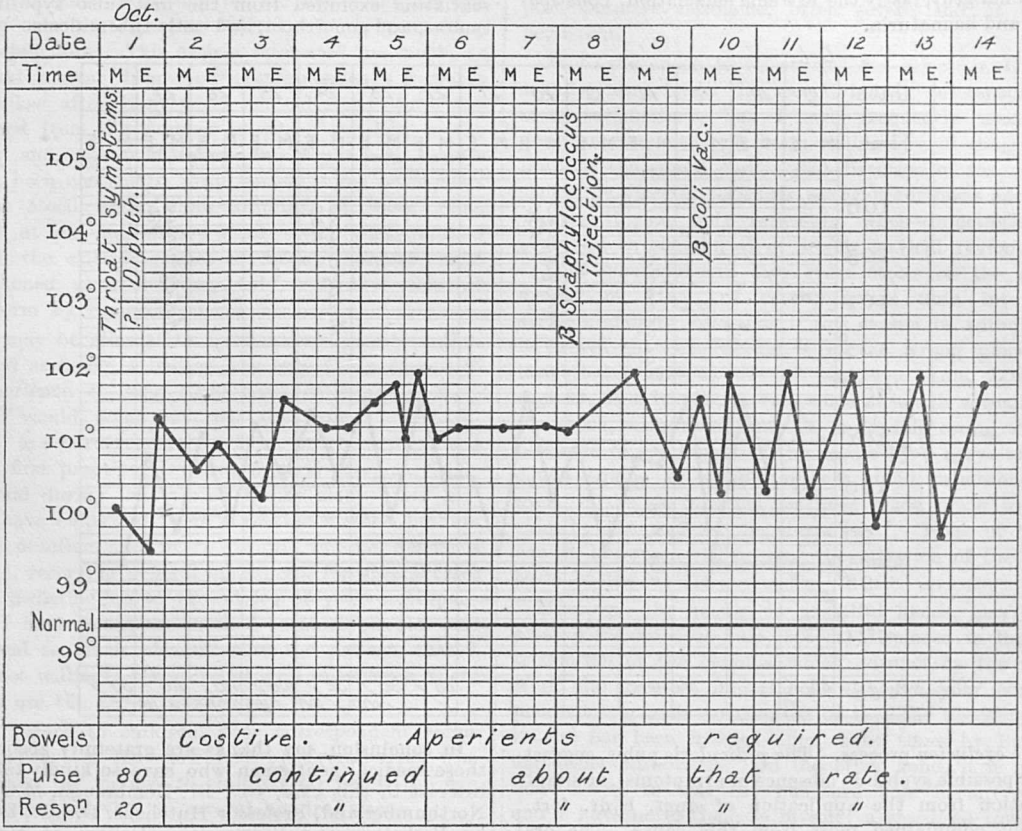
℞ Urotropine with sod. ac. phosph.
Brandy, t.d.s.

Vaccines.—On October 8th vac. of staphylococcus.

October 10th, vac. of B. coli.

October 18th, vac. autogenous (from pus of patient) to be continued bi-weekly.

℞ Tab. ichthyol gr. ii, tab. quininæ gr. i.
Cap. one of each t.d.s.
Continue port wine or vibrona.



On October 18th.—The case looked clinically a case of pellagra. Dr. Slade took specimens of pus and fæces to examine for bacteria and bacilli or evidence of simuliidæ or culcoides, and of the stools for Bilharzia R.

On October 20th.—Pus still exudes from all over the body and limbs, and a large septic focus (cellulitis) just below umbilicus (suprapubic). The pigmentation has turned brown in parts.

October 26th.—Urine examined by Dr. Wells Patterson, who found no albumen nor sugar; considerable deposit of urates; urea amounted to 12 grains per ounce, and indicanuria was present.

"I saw Dr. Spurgin's patient with him on Saturday morning, October 25th, 1913. I found an extremely emaciated youth of 21, whose skin in every part was of a brick-red colour; there was no infiltration, and the skin was dry with a profuse desquamation which was in small scales on the body and limbs, while on the feet the epidermis was separating in quite large flakes. In many places, especially in the axillæ and the legs, there was a discharge of stinking pus through openings in the skin. I was told by Dr. Spurgin that the patient first consulted him on September 8th, 1913, and that the onset of the skin condition was very acute. The amount of desquamation had been very great and continuous in spite of treatment. No history of previous skin disease was obtained. The condition when I saw him, with the exception of the suppuration, was typical of an acute pityriasis rubra of primary type."

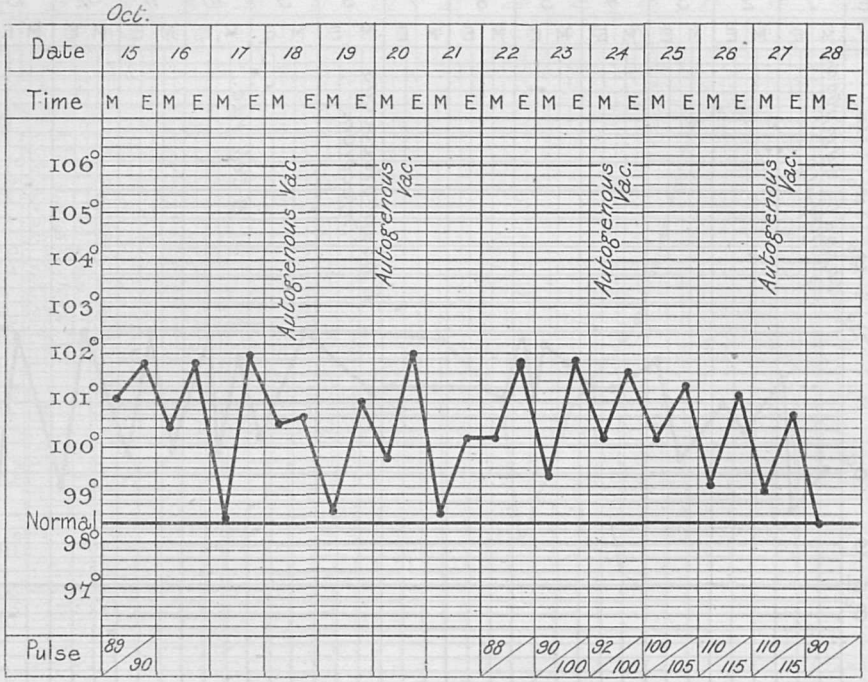
THE DIAGNOSIS OF THIS CASE.

Remarks.

A Priori.—Was the *dermatitis exfoliativa* due to pellagra or sepsis? Was the sepsis due to dermatitis, *e.g.*, by scratching? I take it that dermatitis exfoliativa is the same as pityriasis rubra (of Divergie).

Ab ovo usque ad mala.—It must be remembered that I diagnosed the sunburn rash of a papular erythematous

(ill defined) character upon the sun exposed parts of the patient, when I saw him first on the 8th of September; soon this was masked by the profuse desquamation, and the universal dermatitis. Then vesicles formed, becoming pustular, followed by suppurative cellulitis, and the exudation of foul pus (stinking) exuding from the legs, axillary and inguinal glands, and septic foci innumerable, even over suprapubic region, also scrotum. Mark the pyrexia and hyperæsthesia, dermatitis erythema, pigmentation, langour, desquamation (so profuse as to litter the bed and floor), the slight itching, the amount of pus from septic cellulitis (its character), the neuritis (trembling of the muscles of the upper extremities particularly), the despondency (weeping when dressings were changed), lastly the extreme emaciation, constipation, and hæmaturia.



The *exclusion* process.—The *pediculosis* pubis, suggesting a possible syphilide (absence of symptoms), or simply irritation from the application of ungt. hydr. fort.; patient complained most from this cause. The oral sepsis, foul tongue, constipation at onset. No anæmia.

On September 25th Dr. D. Wells Patterson, of Newcastle, a skin specialist, kindly saw the case with me and expressed the opinion that it was a case of "dermatitis exfoliativa" and very septic, and *not* pellagra. It is generally laid down, I believe, that dermatitis exfoliativa is very rare in its idiopathic form, but it is characterised by disturbed nutrition of the epidermis and its desquamation of minute scales. But the desquamation was not of minute scales, inasmuch as the skin of the palms and soles peeled off in solid masses, and the scales from the body, etc., were large. Note also the absence of colic, vomiting, diarrhœa, or other symptoms of intestinal disturbance, the hyperidrosis of the axillæ which wetted the bed, the throat symptoms suggesting diphtheria which so quickly cleared up.

A *dermatitis* may supervene from many causes, *e.g.*, burns, scalds, traumatism, hair dyes, drugs, and irritants, plants, lead, etc. Is this disease sui generis? Was the dermatitis caused by pellagra or sepsis? Was the sepsis due to dermatitis? *Ad huc sub judice iis est!*

Dr. Slade, the bacteriologist, is still busy cultivating by incubation the specimens he so kindly took. In all the solid media staphylococcus aureus has grown. No aspergillus and no amœbæ have been found. In a microscopical examination of the urine B. coli and B. staphylococcus were found (corroborating my diagnosis given to the relatives at onset of case, viz., septicæmia). No albumen. Enteric and diphtheria were negatived; scarlatina excluded from the first, also syphilis and typhus, and gonorrhœa, and lastly tuberculosis.

In conclusion, my thanks are gratefully accorded to those medical gentlemen who have so kindly taken an interest in this case, viz., Dr. Hembrough, M.O.H. for Northumberland, Professor Hutchens, D.S.O., Lecturer on Pathology and Bacteriology, College of Medicine, Newcastle-on-Tyne and Durham, Dr. Kerr, M.O.H. for Newcastle-on-Tyne, Mr. Leech, Assistant Surgeon to Newcastle-on-Tyne Infirmary, Dr. Wells Patterson, Clinical Dermatologist, College of Medicine, Newcastle-on-Tyne and Durham, Dr. Slade, Bacteriologist and Pathologist.

Apologising for the prolixity of this report,—I am, yours faithfully,

W. H. SPURGIN,
M.R.C.S., L.S.A.
(late of Guy's Hospital.)

8, Graingerville South,
435, Westgate Road,
Newcastle-on-Tyne.
October, 1913.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—ED., G.H.G.]

Notes on Spinal Stovaine Anæsthesia.

SIR,—Will you grant me a little space to criticise to some extent the article on the above subject appearing over the signature "H. L. J." in your issue of October 25th. This article interested me much, as it would appear from your correspondent's remarks that at last after many years our old Alma Mater has awakened from the slumber in which she has, to the wonder and regret of many old Guy's men besides myself, been content to wrap herself. For seven years she has stood aside while hospitals of lesser fame worked at an innovation which, even when viewed through the critical glasses of modern surgery, must be reckoned as a discovery only second to that of chloroform by Simpson.

If I may be allowed to speak as one having authority, and as being, I believe, the only Guy's man with an experience of over 1,500 cases of stovaine analgesia, I would point out that the words "until recently" are hardly correct. It is nearly seven years since I first practised Barker's method of spinal analgesia, and during that period I, like many other surgeons, have employed it *as a routine method* both in private practice and in the wards of the Seamen's Hospital, reserving general anæsthesia for special cases in contra-distinction to the advice of your correspondent. I have found the method so much simpler and safer, and so much pleasanter to the patient, that I would not willingly return to general anæsthesia where I could use the newer method.

With regard to children, your correspondent seems to be unaware of the work done by Tyrrell Gray who has applied the method to children far below the age of 12 years, and that in several hundred cases.

The capacity of the syringe (your correspondent advises 4 c.c.) is immaterial provided it can contain the requisite dose, but it seems to me a pity to ignore the syringe introduced by Barker several years ago, than which none better has as yet been put on the market, and which holds slightly over 2 c.c. It is quite unnecessary to boil the syringe and needles in *distilled water;* ordinary tap water is all that is necessary, and in country practice is more easily obtained.

Your correspondent says that "from the patient's point of view it is preferable that the injection of the anæsthetic should be done in bed." I cannot deny this—he would probably prefer the whole operation to be done in bed—but that this would suit the surgeon or be safe for the patient I think most of us would stoutly deny. If there is one thing certain about spinal analgesia it is that the injection should be done on the operating table, and that the patient should be subjected to no more movement than can possibly be helped. Owing to the "give" of a bed, such injections (often difficult enough on the table) must at times result in such unnecessary pain to the patient and in many failures to the surgeon, while the movement necessary to transfer the former from the bed to the table is the surest means of bringing about post-operative headache, often severe and at times persistent.

As to the space to be utilised for injection, I, personally, have found the second lumbar interspace the most satisfactory, but I have frequently used the dorsi-lumbar, although I am well aware of the lowest limit of the spinal cord. The direction of the needle should be *directly forwards,* and not forwards and upwards; this is only necessary when injections are practised in the dorsal or lower cervical region.

Your correspondent lays great stress on the withdrawal of 2 c.c. of cerebro-spinal fluid into the syringe, and suggests that if this cannot be withdrawn it proves that the needle is in the wrong place, or that it has slipped out of position. This, I would suggest, is only partly true, since although actually in the theca, withdrawal may be impossible owing to the blockage of the lumen of the needle by a nerve of the cauda equina or a fold of arachnoid membrane or even, if the perforation has been made much to one side, by the wall of the theca itself. None of these causes, however, will prevent the injection of the contents of the needle.

Moreover, the needle, in unskilful hands, may, even after withdrawal of fluid, become displaced in the introduction of the cannula, which adjunct, by the way, is of the greatest importance, although your correspondent has made no mention of it. The necessity for its use has been insisted upon many times by Barker and other authorities. On the other hand, it is quite unnecessary to seal the puncture hole in any way, and I have never done so myself; a sterilised towel is simply placed beneath the patient's back, and by the end of the operation it will be found that this tiny wound is sealed by natural means.

The statement that the sitting position is a suitable one for anæsthetisation of the legs is only partly correct: the nerves of the lower extremities, coming as they do from the upper as well as the lower part of the lumbar plexus, may be only partially affected by an injection in the third interspace, when the sitting position is used, as the stovaine frequently sinks at once to the extremity of the theca from whence it is not easily dislodged, even when the patient is placed

in the supine position. The lateral position, although not always the easiest in which to inject, is always the best, and saves much movement on the table, and so obviates post-operative headache.

The use of scopolamine and morphia, or of C.E. mixture, is, to my mind, not only unnecessary, but unwise, since it is difficult to estimate the height to which the analgesia has risen when the patient is half unconscious as the result of these drugs.

The solution advised in the article contains, I note, epirenine borate, and with this I would emphatically find cause to disagree with your correspondent. If the intention is to produce deeper and more lasting anæsthesia it is, in my experience, quite unnecessary: stovaine is a powerful and reliable drug and requires no such assistance; and when one considers the tenuity of the arterioles of the spinal cord and the powerful vaso-constrictor properties of all suprarenal preparations, one is forcibly reminded of the old experiment of compressing the rabbit's aorta, and of the melancholy results accruing therefrom to that useful but unfortunate rodent. That the delicate organisation of the anterior cornual cells should be jeopardised by the use of so powerful and unnecessary a drug seems to me to be little short of unscientific folly; and it is, I have little doubt, to this that certain cases of permanent paresis reported from the Continent have been due. I can see no reason for using any other preparation of stovaine than the Stovain-Billon of Barker's formula; it is about as perfect as any drug can be.

I note, further, that your correspondent advises a dose for an adult of *·08 grm.* and *for an infant of from ·02 to ·04* (the italics are mine)! Can he really mean this, or is it a typographical error? I should be very sorry to administer these doses in the course of my work. An infant may possibly take ·02 grm., but what about ·04 grm., which is a full dose for a boy of 15? The dose I have always employed for adults has been ·06 for a man and ·05 for a woman unless she has been well developed, and even this is ·01 grm. in excess of Barker's doses. Only twice have I exceeded a dose of ·07 grm., having once given ·08 grm. intentionally, and once ·1 grm. by accident. I feel confident that such doses as your correspondent suggests will sooner or later result in disaster, or at the least in a very large proportion of headaches, vomitings, etc., as they are quite needlessly and dangerously large.

Again, the view expressed as to the sensitiveness of the peritoneum in abdominal operations under stovaine would suggest that the method of spinal analgesia is entirely suitable for such undertakings. This is not entirely correct. *Some of these cases*, it is true, are perfectively insensitive to the most severe interference with the peritoneum, while others, although "dead" so far as their systemic nerves are concerned, are very wide awake indeed to any stimulation of the sympathetic system, so much so that a general anæsthetic becomes an absolute necessity. Space does not allow of my discussing this question at length, but I would refer your correspondent to a paper written by me nearly two years ago containing a report of 65 abdominal sections done under spinal analgesia in which I was able to show that two-thirds of these were done entirely under stovaine, while one-third required the assistance of general anæsthesia. This paper appeared in the *British Medical Journal* for December, 1911.

In conclusion, Sir, if I have seemed unduly critical I would ask your correspondent's indulgence, since I am dealing with a method the good name of which I have much at heart, of which I have had a very extended experience, and which I was one of the earliest among British surgeons to advocate and practise.—I am, Sir, yours faithfully,

32, Weymouth St., W. LAWRIE McGAVIN.

Eastern Mounted Brigade Field Ambulance.

ROYAL ARMY MEDICAL CORPS (TERR. FORCE).

DEAR SIR,—At the present time there is a vacancy for one officer in this unit, shortly there will be vacancies for two. On joining the Territorial Force Officers are given an "outfit grant" of £40. The Pay and allowances during camp of a Lieutenant amount to £1 2s. 1½d. a day. Any further particulars will be given to intending candidates on application to the officer commanding or acting Adjutant, either in person or by letter.—I am, Sir, yours truly, EDWARD J. CROSSE, M.D.

Drill Hall, Grove Road, Luton, Beds. Lieut.-Col. Commanding. Eastern Mtd. Bde. Fld. Amblce., R.A.M.C. (T.F.)

The Fives-Court.

SIR,—I feel I am voicing a very general want among an ever-increasing band of Squash Racquets enthusiasts by bringing up for the second time the question of artificial illumination of the court. There are many more who would be keen enough to play, if they could do so, when their work in the afternoon was over. This is possible for a short time in the summer, but is quite out of the question in the winter months. The scheme could be carried out at a very small cost, and I am sure this would be considerably outweighed by the greatly increased facilities and added stimulus given to the game. Furthermore, it is very desirable that the court should be more often, and more efficiently, swept and cleaned.—Yours very truly, O. G. MORGAN.

Guy's Hospital, London, S.E.

A Tragedy of South London.

A TRULY remarkable play has recently been produced in London. "Between Sunset and Dawn," by Hermon Ould, which preceded "The Green Cockatoo," at the Vaudeville, is certainly one of the finest pieces of modern drama which it has been our good fortune to behold. With their usual gross lack of appreciation of what is, without a doubt, good, Londoners have allowed this play to pass almost unnoticed; have insulted its writer and producers with half-empty houses; and have brought about in a few weeks the failure of a piece which, in an appreciative country, would have won a literary and artistic immortality. We hope that other playwrights of considerable drama will follow the example of Bernard Shaw, and produce their plays abroad. Only by some such means can we hope, eventually, to be shamed into progress, and, by a process of ridicule, humbled into intelligence.

The play in question makes a special appeal to those of us who have the savour of South London in our nostrils. Ireland, Scotland, and Lancashire already have their own dramatic schools, and their own present-day dramas, and now the turn of Deptford, Walworth, and Bermondsey has come. Hermon Ould has written a tragedy which concerns itself with the lives of the men and women we meet on the district, and encounter daily in the surgery. That they are lovable we know: that they are human most of us recognize; but that there is as much—nay more—of passion and emotion, and as much of dramatic incident in their humble lives, as there is in the lives of any other class in any era, is a fact that we are somewhat apt to forget.

Too much do we generalize concerning them in our minds and in our speech. We refer to them kindly or contemptuously as "the submerged tenth," or characterize them as "typical Boroughites," and in the process merely succeed in making manifest our ignorance concerning them.

Writers, who know the lives of those who dwell "across the bridges," we had before, it is true, in Neil Lyons, the novelist, and in Alexander Paterson, and now a dramatist is added to the select list, a dramatist who knows his subject as intimately, and as certainly achieves. Briefly, the play is as follows:—

The scene is laid in a South London doss-house—bare and dirty—kept by an old woman with the customary bonnet of rusty black, and the customary huskiness and tendency to tears of the chronic alcoholic female. The part was admirably enacted.

Her son Jim, burly and heavy-jawed, played magnificently by Norman McKinnel, is the hero. Various doss-house characters are introduced in turn, and finally enters Liz, the wife of Bill 'iggins, Jim's pal, who, by dint of drink and abuse of no worse an order than that which we know to be as inevitable as Saturday night itself is inevitable in our own purlieus, has driven his wife from home. Jim is "taken with" Liz, and protects her from the attacks of her husband who shortly appears upon the scene. The characters disperse, but at a later hour, when the doss-house is quiet, Liz returns to Jim, who kindly but bluntly expresses his sympathy for her circumstances and his love for her person, and succeeds in partially winning her affections. But Liz, in the midst of her distress, keeps tearfully pleading, "an' me a respectable married woman an' all," and with the wonderful constancy that we know to be a truth among the women of her ilk, goes home again the same night to her drunken husband. There is a repetition of conjugal abuse and anger, and Bill grows jealous and suspicious, and this time drives his wife from home with threats of murder.

Once more in the early hours of the wet morning Liz comes back to Jim at the doss-house, and Jim forcibly and passionately makes love to her, and then with his poor mind muddled, and torn between his duty to his pal, Bill 'iggins, and his love for Bill's wife, passes gradually into a strange mood of madness, and in a fit of frenzied, puzzled emotion stabs Liz, as their lips meet for the first time.

Words, and especially inferior prose, can convey no impression of the faithful simplicity of the play, and of the horror of its final scene.

It is terrible, but it is magnificent, and with a few exceptions—notably the accent and diction of Bill and of his mother, who appears in the scene at Bill's Deptford home—is wonderfully well performed.

Sordid, you say. That is no criticism. Macbeth is sordid.

Improbable you suggest. We believe that the motives and circumstances of half the tragedies and murders in South London are in no sense markedly different from the motives and circumstances portrayed in this piece.

R.

Pupils' Physical Society.

The second meeting of the session was held in the Wills Library on Saturday, October 25th, Mr. O. G. Morgan in the chair. The following gentlemen showed pathological specimens:—

Mr. Gould: Liver with secondary deposits (from carcinoma of the pancreas), weighing 21 lbs.

Mr. Garrard: Gumma of the brain.

Mr. Cooke: Sarcoma of the occipital lobe.

Mr. Burnside: Cerebral abscess. In the discussion on these cerebral cases, Dr. Nicholson attributed the sudden death with which some of them end, to œdema of the medulla.

Mr. Miller: Sarcoma of the ileum, with dense adhesions to the pelvic colon, removed by operation.

Mr. Quesada: Papilliferous ovarian cyst. Mr. Miller ably explained how ovarian cyst, as simulating pregnancy, is an attempt of nature to combat intestinal stasis.

Mr. Evans: Fœtus papyraceus, one of a pair of uniovular twins, born at 7 months, the other being alive and healthy.

Mr. Evans: Loose body from knee-joint, thought to be a detached condylar cartilage.

About 30 members were present. As usual, at pathological meetings, discussion tended to become diffused over clinical medicine and methods of treatment, but a large number of students took part, also Dr. Nicholson, and Messrs. Edmond and Maxted. The next meeting of the Physicial Society will be held on November 8th, with Mr. E. S. Taylor in the chair. It will be a clinical evening, and an interesting selection of cases is anticipated.

Notices.

Sixth International Dental Congress.

London, August 3rd to 8th, 1914.

Patron - His Majesty the King.

INTERNATIONAL CONGRESS MUSEUM.

Officers.—Mr. A. Hopewell-Smith, L.R.C.P., M.R.C.S., L.D.S. (Chairman). Mr. F. N. Doubleday, L.R.C.P., M.R.C.S., L.D.S. (Hon. General Secretary).

Honorary Curators.—Mr. H. P. Aubrey, L.R.C.P., M.R.C.S., L.D.S. (Oral Surgery). Mr. C. F. Peyton Baly, L.R.C.P., M.R.C.S., L.D.S. (Oral Hygiene, &c.). Mr. F. Bocquet Bull, L.D.S. (Dental Education). Mr. F. N. Doubleday, L.R.C.P., M.R.C.S., L.D.S. (Dental Surgery). Mr. E. B. Dowsett, L.R.C.P., M.R.C.S., L.D.S. (General). Mr. A. Hopewell-Smith, L.R.C.P., M.R.C.S., L.D.S. (General). Mr. A. E. Ironside, L.R.C.P., M.R.C.S., L.D.S. (Physics, &c.). Mr. S. P. Mummery, L.R.C.P., M.R.C.S., L.D.S. (Pathology). Mr. J. Lewin Payne, L,R.C.P., M.R.C.S., L.D.S. (General). Mr. A. T. Pitts, L.R.C.P., M.R.C.S., L.D.S. (General)

Nature and Scope of the Museum.

It is intended that the Museum shall be an International collection of objects of interest, and be representative of every section of the Congress. Its nature and scope include the following:—

1. Specimens showing the evolution of tooth forms and of the dentition of man. Histological preparations bearing upon recent research. Exhibits illustrating the chemical composition and physiological action of the saliva.

2. Specimens of morbid conditions of the teeth, palate, gums, and jaws, such as odontomes, dental and dentigerous cysts, new growths, diseases of the periodontal membrane, etc. Photomicrographs of oral micro-organisms, and cultures of micro-organisms in test tubes or in petri dishes. New bacteriological apparatus and appliances.

3. Specimens of teeth, gums, and jaws affected by "pyorrhœa alveolaris." Microscopical and lantern slides of the same. Exhibits of various new methods of "inlaying" cavities in teeth. Exhibits of new methods of "crowning" teeth.

4. Radiographs of the normal dental tissues, and of diseases of the same and associated parts.

5. Exhibition of various kinds of articulators. Specimens showing the various methods of "pressure casting." Specimens showing modern forms of continuous gum work.

6. Models showing abnormalities in position of the teeth, and appliances for the correction of the same.

7. Specimens illustrating methods of dealing with surgical conditions of the teeth and jaws, including cleft palate, harelip, fracture and resection of the jaws.

8. Specimens illustrating the history and evolution of anæsthesia.

9. Photographs, charts, diagrams, specimens and statistics of school clinics. Methods of the instruction of the public in the principles of oral hygiene.

10. Instruction forms, charts, diagrams, specimens, and demonstration models used in relation to dental education. The specimens will include those employed for teaching purposes, and also specimens of work of both students and pupils, completed in accordance with the definite courses given.

11. Historical objects of interest, such as books, instruments, pictures, etc.

Intending exhibitors should write for the regulations and application and entry forms to Mr. A. Hopewell-Smith, International Dental Congress Office, 19, Hanover Square, London, W. They should write as early as possible as all applications must be returned to the Museum Committee before June 30th, 1914.

Examining Board in England.

By the Royal College of Physicians of London and the Royal College of Surgeons of England.

The following are the dates on which the examinations will commence for the year 1914:—

First Examination.—*Chemistry and Physics: Tuesdays—December 30, 1913; March 24; July 14th; September 29. Biology: Wednesdays—December 31, 1913; March 25; July 15; September 30. Practical Pharmacy: Thursdays—January 8; April 2; July 9; October 8.

Second Examination.—Physiology: Thursdays—January 1; March 26; July 2; September 24. Anatomy: Fridays—January 2; March 27; July 3; September 25.

Third or Final Examination.—Medicine: (1st Paper) Tuesdays—January 6; March 31; July 7; October 6. (2nd Paper) Wednesdays—January 7; April 1; July 8; October 7. Midwifery: Thursdays—January 8; April 2; July 9; October 8. Surgery: Fridays—January 9; April 3; July 10; October 9. (Practical Pharmacy, *see* First Examination.)

*The examination in Practical Chemistry will be held on Fridays, January 2, March 27, July 17, October 2.

Candidates intending to present themselves for examination are required to give notice in writing to the Secretary of the Examining Board in England, Examination Hall, 8–11, Queen Square, Bloomsbury, London, W.C., fourteen clear days before the day on which the examination commences, transmitting at the same time the required certificates.

All candidates are required to produce certificates of age when entering for the first time for any part of the final examination.

All fees must be paid not less than three days prior to the day on which the examination commences.

Synopsis indicating the range of subjects in the examinations in chemistry, physics, elementary biology, practical pharmacy, physiology, forensic medicine, and public health may be obtained together with the regulations.

Notice to University Candidates.—Candidates are reminded that they should send with the schedule of certificates when applying for admission to the final examination, a certificate from the Registrar or other official of the University showing that they have passed examinations in the subjects of the earlier examinations of the Board.

N.B.—Books of questions set at the several examinations of the Board for each year from 1887 to 1913 may be had on application to Messrs. Taylor and Francis, Printers, Red Lion Court, Fleet Street, London, E.C. Price 6d. each, post free 6½d.

FREDERIC G. HALLETT, Secretary.

Reviews, etc.

Books for review should be addressed to The Editor, Gazette Office, Guy's Hospital, S.E. Their price should in every case be stated.

Ionic Medication: The Principles of the Method and an Account of the Clinical Results Obtained. By Lewis Jones, M.D. (H. K. Lewis.) Price 5s. net.

The author states that this work on ionic medication is written in consequence of inquiries that have been put to him. He defines it as the use of electricity in introducing drugs into the superficial parts of the body through the surface, and also in modifying the chemical constitution of parts of the body by setting up chemical interchange. That drugs can be made to penetrate the skin is easily shown by using cocaine ions which will produce cutaneous anæsthesia. Whether in all the diseases mentioned the drug driven in produces the good effects described is not so certain. For instance, we doubt whether zinc ions in the prostate produce the relief of symptoms described on page 71. It seems just as probable that the effect of the current alone on the bladder might have had the same effect. Dr. Lewis Jones evidently feels the force of this criticism, for in another place he meets it by saying that in his opinion good results are more certainly and rapidly produced when an electric current is used with an ion like the salicylic acid or quinine than when it is used without. A full record of the actual clinical results obtained is given, and where the author draws from his own experience the accounts are clear and moderate. Unfortunately the completeness at which he aims has led him to quote from writings which so far lack confirmation. As an example we doubt whether lateral curvature of the spine is due to pleural adhesions or whether the only effective treatment is electrolytic sclerolysis.

The chapters dealing with the theory of the subject and the practical details are excellent.

Rugby Football.

GUY'S v. CAMBRIDGE UNIVERSITY.

"Much as most other sides would have fared"—a remark overheard at the Ground on Wednesday, October 22nd, when the above match was played and which referred to the defeat of the Hospital by 39 points to 8. There are very few sides who would have done very much better, that is the better way of putting it. The Varsity were splendid, and forward and behind there was not a weak spot that anyone, except a carping critic, could find. Their forwards were very quick on the ball; they handled well, and were always doing something. Their backs, with four Internationals, were superb.

The pace of the backs, aided by not very good tackling on the part of Guy's centres and halves, led up to the first score, a try by Will. The movement from Lewis to Wood and then to Will was carried out at a great pace. One had to be near enough to tackle, as they had the pace of the Hospital men. Wood next sent Lowe off, Lewis, the last to receive, scoring. Blair and Lowe were the next two to gain tries, the last one well judged by Lowe who took the ball well and in full stride. It should be mentioned the ball bounced kindly for him. Blair was the next to dash over by the posts. Greenwood having kicked 3 goals, the Varsity score stood at 21 points. Roberts got a try for the Hospital which Medlock converted, and Guy's were led at half-time by 21 to 5.

Resuming, for a time the Varsity were held in check. Although Tweed had joined the backs, our seven forwards were playing manfully. A good dribble and a very smart pick up by Steyn, who got a try by the corner too wide for conversion, was the next feature. But Cambridge soon got going again, and scored five more tries through Lowe, Will, Wood, and Maynard; three times Greenwood converted, making the final score: Cambridge University, 6 goals 3 tries, 39 points; Guy's Hospital, 1 goal 1 try, 8 points. Teams:—

GUY'S.—A. H. Harkness (back); †*S. S. L. Steyn, C. L. Curle, R. Crook, A. F. Rook (three-quarters);

*L. R. Broster, C. H. Medlock (halves); C. S. L. Roberts, O. Parry-Jones, M. Tweed, A. S. Liebson, C. H. Laver, E. F. Llarena, A. B. Danby, G. F. Kidman (forwards).

CAMBRIDGE.—†*W. M. Wallace (King's) (back); †*C. N. Lowe (Pembroke), *C. Thorne (Clare), G. E. C. Wood (Pembroke), †*J. G. Will (Downing) (three-quarters); *B. S. Cumberlege (Emmanuel), †C. Lewis (St. Catherine's) (halves); †*J. E. Greenwood (King's), †*P. C. Blair (King's), *W. C. Nield (Clare), *A. H. Wilson (Pembroke), *A. F. Maynard (Emmanuel), A. Vincent (Pembroke), W. D. Doherty (King's), W. J. McCombie (Caius), (forwards).

* Blues. † Internationals.

REMARKS.—The forwards did very well indeed, but must mark more thoroughly from the line out, and also must tackle low. Roberts led his men excellently. Laver played another good game; also Parry-Jones and Liebson. Broster was handicapped by the seven forwards not getting the ball away clearly. Medlock had, for him, rather an off-day, but his opportunities were limited. Steyn and Rook did all they could; both tackled well, but the others will go too high. It is so essential, that reiteration is excusable: the tackle should be low and not shoulder high. It is bad football to catch at a man's arm or head; go for him low and put him down at once. Harkness gave a very good display indeed; some of his kicks were splendid. The whole team played very pluckily indeed, and are to be congratulated on never "getting their tails down." We are not at all disheartened, but are, on the other hand, certain that the Hospital will rapidly settle into a really good side. Keenness is there and that is everything.

GUY'S v. ROSSLYN PARK.

This match was played at Honor Oak Park, Saturday, October 25th. Determined to do something to wipe out, if possible, the flavour of the defeat inflicted by Cambridge, the Hospital at once started to attack, and handling in much improved fashion the ball was worked out to Rook, who ran in favourably for Medlock to goal. The advantage gained thus early was somewhat balanced by a try, unconverted, gained for the visitors by Soutar, who received near the line and dropped over after a short run. Taking the kick himself Soutar had the ill-luck to hit the wrong side of the upright. A lovely opening was made for Curle just after, but he missed his pass badly. Liebson next came into the picture, punting high and following up very fast, he caught the ball clearly, and, showing good speed, dashed on for an excellent try, which Medlock just failed to add to. Broster was the next to get over, very wide out, the passing that led up to it being excellently done. Morris, for Rosslyn Park, scored an unconverted try, after a strong forward rush, just before Broster's try; so that ends were changed Guy's leading by 11—6.

The second half was mainly in our favour, and the most notable feature was the running of Steyn and the pace of our forwards. The three-quarters handled well for Steyn to complete the effort by scoring near the corner. Tweed then handed on to Steyn, who again got over. Laver next completed a good piece of work by passing to Steyn, who once again got a try. Steyn kicked a goal from his second try. A. L. Anthony, playing as substitute for the visitors, was the cause of Guy's defence temporarily breaking down. He headed the Park forwards and got past our defence to score near the posts. Again Soutar was unfortunate enough to hit the post and see the ball rebound the wrong side. Score:—Guy's, 2 goals 4 tries, 22 points; Rosslyn Park, 3 tries, 9 points. Team:—

GUY'S.—H. Millett (back); S. S. L. Steyn, C. L. Curle, A. H. Harkness, A. F. Rook (three-quarters); C. H. Medlock, L. R. Broster (halves); C. S. L. Roberts, O. Parry-Jones, M. Tweed, A. Liebson, C. H. Laver, E. F. Llarena, G. F. Kidman, C. G. Haynes (forwards).

REMARKS.—The return of Millett and Harkness improved the side, Millett being very safe, and Harkness handling and defending well. Steyn had opportunities and used them well. Broster and Medlock played much better together. Curle does not seem quite happy yet. Rook played very well. There is still too much high tackling, but the marking from the "line out" was much better. The forwards showed much more cohesion and played their best game so far.

PAPERS RECEIVED.—Nursing Times, Hospital, St. Mary's Hospital Gazette, St. Thomas's Hospital Gazette.

Birth.

CRAIG.—On the 24th October, at 54, Welbeck Street W., the wife of Dr. Maurice Craig, of a daughter.

Marriages.

LACEY—BARBER.—On Thursday, October 23rd, at St. Andrew's, Hertford, Herts., by the Rev. N. T. Gardner, Rector, William Stocks Lacey, L.R.C.P. Lond., M.R.C.S. Eng., L.D.S. Eng., D.M.D. Harvard, only son of Mr. and Mrs. William J. M. Lacey, of Clyde House, Hertford, to Mabel, only daughter of Mr. and Mrs. Thomas Barber, of Castle Street, Hertford.

JARVIE—STRAPPINI-CANNING.—On October 22nd, at Kirk Braddon, Douglas, I.O.M., by the Rev. H. S. Taggart, M.A., assisted by the Rev. W. A. Rushworth, M.A., James Milne Jarvie, B.A., B.C., son of the late Rev. A. M. Jarvie, of the Scots Church, Sydney, to Constance Strappini-Canning, younger daughter of the late M. Canning, Esq., Douglas, and adopted daughter of the late P. A. M. Strappini, Barrister, London.

G. T. M.

GUY'S HOSPITAL GAZETTE.

VOL. XXVII., No. 663.] NOVEMBER 22, 1913. [SIXPENCE.

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Passim.

HOW long does a man take to qualify? This is a question we are often asked by friends outside, and one that we frequently speculate upon among ourselves. Speaking personally, we were of the opinion that on the average more than 50 per cent. of medical students took over seven years to qualify and, as a natural corollary to this belief, we have been in the habit of estimating the cost of obtaining a registrable qualification at a very high figure. We are therefore very pleased to find that our guess considerably overshoots the mark. A return has recently been prepared in the Medical School Office showing the time taken by men in qualifying during the last five or six years.

It appears that the average time taken by all men is six years and two months; 76 per cent. qualify in seven years or less, and just 50 per cent. in six years or less. These figures are very striking testimony to a high average of ability among medical students, and in addition suggest that as a body they are very industrious. When one considers that there are three or four examinations, each consisting of two or three subjects to be passed, that in all of them a reasonably high standard is exacted, and further that during our first year or two we are going through a transition stage, realizing we are free from the external discipline of school, but not yet understanding that we must replace it by a more exacting personal discipline, it is remarkable that most of us lose so little time in a curriculum which can just, and only just, be squeezed into five or five and a half years. It must also be remembered that this average figure of slightly over six years includes those men who turned aside from the straight course for six or twelve months for the Primary Fellowship Examination and also those who have to interrupt their work for long or short periods on account of illness or other troubles. On the whole then one is fully justified in saying that the man of average ability who works steadily can be quite certain of qualifying in less than six years.

These figures apply only to men doing the London or Conjoint courses from the beginning in the Hospital. The average for Oxford and Cambridge men is probably about a year longer, since they give more time to the pre-clinical part of the course.

THOSE of us who have enjoyed the delights of Take-in House-Surgeon will remember that one of the chief troubles of that happy, if overworked, officer is the difficulty in finding an anæsthetist on the afternoons on which his surgeon operates. A good deal of this trouble was due to the fact that the understanding, that on four afternoons a week the Take-in firm should have the first claim on the services of a Staff Anæsthetist, had been allowed to lapse, and had practically slipped out of memory. The rota of attendances of the Staff Anæsthetists has

recently been re-arranged, so that now there will be two anæsthetists present on Monday, Tuesday, and Thursday afternoons, and three on Friday, the busiest afternoon of the week.

One of the anæsthetists will be definitely attached on each afternoon to a particular surgeon, and the other one will be primarily free for the Take-in firm of the week. This definite re-statement of the priority of claim of the Take-in H.-S. will enable him to take his lunch in peace instead of spending that hour in frantic appeals to the good nature and keenness of his colleagues. The rota of attendances of the Staff Anæsthetists and the surgeons to whom they are attached on each day is printed at the foot of the operation sheets for the day that are hung in the Theatres.

We publish elsewhere in this issue a notice of the forthcoming concert of the Musical Society, It is to be held on Friday, December 12th, at 8.15 p.m., in the Physiological Theatre. A very interesting and attractive programme has been arranged, and we understand that the Society is making a special effort in order that this concert may surpass all its previous successes. It is hoped that a large proportion of the music-lovers in the Hospital will make a point of being present. We can promise them a really good evening's entertainment, and they will have the added satisfaction of helping to preserve in Guy's the spirit of music. Tickets, price 2s. 6d. and 1s., may be obtained from the hon. secretaries, Messrs. H. Q. F. Thompson and J. J. Sterling Hill, or from the Matron's Office.

A very fine collection of heads of various types of big game has just been hung in the College Dining Room. There are in all 21 specimens, and included in the number are two very fine specimens of buffalo and two skulls of that weird animal, the wart hog, to say nothing of various types of deer, each with more wonderful and curious horns than its neighbour. The whole group has been very skilfully mounted, and greatly improves the appearance of the hall. The animals were all shot during the last two or three years by Mr. H. L. Duke, who is, as his contemporaries know, in the Uganda Medical Service. Mr. Duke has deposited them on loan with the Students' Club for three years, and we understand that there is a possibility that some of them or similar specimens may finally become the property of the Club.

The establishment of the Gazette Museum of Antiquities as a repository where all objects, possessing through their association with Guy's an historical interest, will be suitably preserved and looked after is already being justified. One of the most recent acquisitions is a large framed collection of autograph letters from various members of the Guy's Staff in the early part of the nineteenth century. These letters were presented to the Museum by Mrs. Taylor in celebration of her 98th birthday. Mrs. Taylor is the widow of an old Guy's man, who was, we believe, one of Astley Cooper's dressers, so that she forms a link with the great past of the Hospital. Mrs. Taylor's two sons and two of her grandsons have all been Guy's men. We can assure Mrs. Taylor that all Guy's men interested in the past history of the Hospital will be very grateful to her for a very valuable gift.

On Saturday, December 6th, the Physical Society will hold their Annual Discussion, which has in recent years become the most important and most successful of their meetings. The subject for discussion this year is a familiar one at meetings of all medical societies. But "The Treatment of Syphilis" will not, we are sure, cease to be for many years one of the most interesting branches of therapeutics, as well as one of the most controversial. The choice of this subject for the present session is particularly appropriate in view, firstly of the fact that we are now in a position to consider provisionally the results of treatment with salvarsan, and also because public interest upon the subject has been stimulated by the resolutions of the International Congress of Medicine and by the consequent appointment of a Royal Commission upon Venereal Disease. The results of this increased interest in the

subject have been visible in the columns of some of the daily newspapers and in most of the monthly reviews. These articles have all been commendably frank in their treatment of the subject and will undoubtedly cause a demand among our more intelligent patients for that full and active treatment which has been so often lacking in the past.

The discussion will be opened by Major Pollock, R.A.M.C., and will be continued by Dr. J. P. Porter Phillips, of Bethlem Hospital, and by Dr. Eyre and Mr. A. R. Thompson. We can promise all who turn up a very interesting and instructive evening, and would urge everyone to make a point of being present. We need hardly remind old Guy's men that they are heartily welcome at all the meetings of the Physical Society.

MR. T. B. LAYTON will hold classes for recent recruits to the Officers Training Corps at 5 p.m., on Thursdays, in Class Room No. 2. The first class will be held on Thursday, November 27th, and they will be continued to the end of the term. All those men not recruits, who are genuinely interested in the work and aims of the corps, will also be welcome to attend the classes.

Appointments.

Military.

Captain J. H. Horton, D.S.O., I.M.S., promoted Major, from July 21st, and appointed Personal Assistant to the Surgeon-General with the Government of Bombay, Poona, India, in October.

Civil.

Arthur H. Crook, F.R.C.S., to the Staff of the Princess Alice Hospital, Eastbourne.

H. W. Barber, M.B., B.C., to be Physician to the Skin Department, Evelina Hospital for Sick Children, Southwark.

José Maria Barrionuevo, B.A., B.Sc., to be Assistant-Surgeon to San Juan de Dios Hospital, San José, Costa Rica; Secretary of the Faculty of Medicine, Costa Rica; Delegate of the Government and the Faculty of Medicine to the First Central American Medical Congress.

F. G. Lloyd to be Resident Medical Officer to Out-Patients, Queen Charlotte's Lying-in Hospital, Marylebone, W.

The Resurrectionists.

VIII.

"But long before they passed the ferry,
The dead that he had help'd to bury,
He sack'd—(he had a sack to carry
The bodies off in).
In fact, he let them have a very
Short fit of coffin."

Jack Hall, HOOD.

For some of the most intimate details of the body-snatching business we are indebted—not to a surgeon or a professed man of letters—but to a working resurrectionist, or, as he playfully termed himself—though we may here suspect the assistance of some scholarly student—a "Resurgam Hommo."

Our author is the same Josh Naples, of whom we have already spoken. Bransby Cooper invariably refers to him as N——, for the man had been in respectable employment in the dissecting-room at St. Thomas's until shortly before the "Life of Sir Astley Cooper" was published; and it is owing to the researches of Mr. J. B. Bailey that the full name has since been ascertained.

Bransby speaks of him as a civil and well-conducted man, slight in person, with a pleasing expression of countenance and of respectful manners. Like his partner, Bill Harnett, he was generally at enmity with Ben Crouch; but, unlike Bill, a brave man and a good boxer who once fought a pitched battle with Crouch at Wimbledon, he was of a timorous disposition, and consequently little to be relied on in face of opposition.

In early life he had been a seaman in H.M.S. *Excellent*, and had served in her at the battle off Cape St. Vincent in 1797. Later on he deserted from the service and got employment as a gravedigger in the Spa Fields burial ground where his initiation into the mysteries of body-snatching led to the first of his many terms of imprisonment.

One of his later literary efforts has reference to his incarceration in Maidstone Jail for robbing a churchyard at Woolwich. It opens with a commentary upon some of the prison officials:—

"Maidstone Gaol, Oct. 21st, 1813.

Thos. Cutbush, Governor, a d—d old file, chained my hands to my waist, from Maidstone unto Newgate.

Thos. Stephens, head turnkey, very good man.

Stephen Page, under turnkey, ditto."

The remainder of this record is a catalogue of his fellow-prisoners, including eight men who were serving two years apiece for "conveying to the coast French prisoners," and

"Joe Lester, second at a fight, the man was killed at Woolwich
Mich. Oram killed the man } for trial

T. Salmon, smuggler,
Rich. Shilling, ditto } King's pleasure."

Besides these, D. Rochester and H. Cook are serving a year for swindling, "J. Perrott, defraud, two years; Jn. Horam, housebreaking, *suffered death;* Jn. Caid, ——, seven years; J. Hawthorn and R. Simmons, *smashers*, six months;" as well as "Josh Naples, Resurgam Hommo, for trial."

A couple of years previously he had begun to keep what he called his "log-book," of which the earlier portion alone remains. This diary came into the possession of Bransby Cooper after the traffic in exhumed bodies had ceased, and his former dresser, Sir Thomas Longmore, who had assisted him in writing the famous "Life," eventually presented the record to the Royal College of Surgeons. It was afterwards brought to light by Mr. James Blake Bailey, the College librarian, who in 1896 published it in full, with an extensive commentary, under the title of "The Diary of a Resurrectionist."

So much of the diary as is still extant relates to the years 1811 and 1812; but, as Naples stated on another occasion that full employment in the previous two years had accounted for over 300 adult bodies, it will be sufficient here to confine ourselves mainly to the operations within the hospital district rather than to transcribe the entire record.

Here and there the terminology employed requires a note of explanation. The word "crib" is used to denote a burial-ground. Cadavers are "things," and Naples in his differential count discriminates between "large" and "small," that is, between adult bodies and those less than three feet in length. Those which most nearly approach this standard are "large small," and, in another flight of scholarship, the body of an infant is spoken of as a "fœtus." The word "opened" implies that a body has already been the subject of a *post-mortem* examination.

"Thursday, 28th Nov., 1811. At night went out and got 3. Jack and me Hospital Crib, Benjn., Danl., and Bill to Harper's. Jack and me 1 Big Gates, sold 1 Taunton, do. St. Thomas's."

Here it would appear that the official burial of either Guy's or St. Thomas's was violated. Big Gates seems to describe another graveyard in the vicinity. Harper, mentioned on several other occasions, seems to have been a sexton or a watchman. The purchaser of the first subject was the John Taunton who afterwards founded the London Truss Society; he was once a demonstrator under Cline, and at this time a lecturer to the London Anatomical Society.

"Tuesday, Dec. 24th, 1811. At 12 at midnight party went to Wygate, got 3 small, came back and got 2 large at Newington. Came home, then settled at Ben's. Each man's share £8 16 8. At home all night.

Wednesday 25th and Thursday 26th. At home all day and night.

Friday 27th. Went to look out. Came home met Ben and Danl. at 5 o'clock. Went to Harp.'s, got 1 large and took it to Jack's house. Jack, Bill and Tom not with us, getting drunk.

Saturday 28th. At 4 o'clock in the morning got up, with the whole party to Guy's and St. Thomas's Crib, got 6, took them to St. Thomas's and met at Thomas's again, pack'd up 3 for Edinbro, took one over to Guy's."

It is to be observed that at the end of this strenuous Christmas week one body is delivered at Guy's, although the United Hospitals at this time had their joint anatomical school at St. Thomas's and the large majority of subjects were carried there. In this instance it is probable that the body was required for the semi-private dissecting room which Sir Astley, following his uncle, William Cooper, maintained there.

"Tuesday 31st. Met at the Harty Choak, had dispute about the horse."

The sign of the "Artichoke" and that of the "Rockingham Arms," which occurs later, are sufficiently uncommon to leave little doubt that the public houses at the two extremities of Newington Causeway are in question. The "White Horse," which is mentioned also, was formerly to be found nearer St. George's Church.

"Friday, January 10th, 1812. Met at St. Thomas's, settled. Each man's share £12 12. 3 things on hand.

Saturday 11th. At 4 a.m. got up and went to the Hospital Crib, got 2 adults: met at Barthm. Packed up 2 for the country. Sold one at St. Thomas's. At home all night.

Tuesday 14th. At 1 a.m. got up. Ben, Bill and me to St. Luke's, 2 adults, Jack, Dan to Big Gates, 1 large and 1 small, took them to Barthm. Came home and went to St. Thomas's, afterwards went to the other end of the town for orders, at home all night.

Wednesday 15th. Went to St. Thomas's. Came back, packed up 2 large and 1 small for Edinbro. At home all night."

Here, as on other occasions, it is quite within the bounds of possibility that the "two large and one small" were dispatched from London "*by Pickford's van*" like Mary's "trunk" when she protested

"*I don't half like the outside place*
They've took for my inside."

The famous carrying firm of Pickford's was first established towards the end of the seventeenth century, and maintained an important service for conveying heavy luggage between London and the great provincial towns until the coming of the railways.

"Thursday 16th. The party met at the Hartichoak, settled the above. Each man's share £8 4 7½d. At home all night.

Friday 17th. Went and look out, came home and met at 11, party except Danl. went to the Hospital Crib and got 4, was stopt by the patrols, Butler's horse and cart were taken.

Saturday 18th. Went to the White-horse, Butler bailed, at home all night.

Sunday 19th. Went and looked out, at home all night, could not get the horse out of the stable.

Monday 20th. At home all day and night. Butler Jack got drunk.

Tuesday 21st. Looked out. Jack and Butler drunk as before, hindered us going out, at home.

Wednesday 22nd. At 4 o'clock in the morning got up, Bill and me went to the Hospital Crib and 1 for Mr. [Astley] Cooper's lectures, had a dispute with the party, at home all night. Ben got drunk.

Friday 24th. Met at 11 at night, met the patrols. Got one Hospital Crib and 6 at Bermondsey, took them to Bartholm., sent 3 to the country.

Tuesday, March 4th. Met at night, went to Guy's got 3 adults.

Friday 7th. Met together, me and Butler went to Newington, thing bad. . . . Came home, met again, Danl., Bill and me went to St. John's got 2 adults; Ben and Jack went to Flemish, got nothing, took 2 St. Thomas's."

After their disappointment in unearthing a putrid subject at Newington, the body-snatchers met with more success at St. John's, Horselydown. Crouch and Harnett, however, met with no success at the Flemish burial-ground belonging to the parishes of St. Olave and St. John's, Southwark, on the site now occupied by the London Bridge Stations and their approaches.

" Wednesday 12th. Went to look out, met at night, went to St. Olave's. Got 2 adults and 1 do. Bermondsey, took them to St. Thomas's.

Tuesday 25th. At home all day. At night met at Jack's to go to Harp.'s, the moon at the full, could not go.

Thursday 27th. Went to St. Thomas's. Sold the extremities. Tom and Bill got drunk at the Rockingham Arms. At home all night.

Friday 28th. Went to St. Jn.'s, Ben not with us, work'd two holes, one bad, drew the Cns. and took the above to St. Thos."

Thursday's subject was apparently not wholly good, but it was better than that raised next day in which the canine teeth (Cns.) were the only features worth removing.

It would be tedious to quote further from the diary and enough has already been transcribed to suggest the methods and the contrasting characters of this band of ruffians. Seven of his associates are named named by the diarist: Ben (Crouch), Bill (Harnett), Jack (Harnett), Butler, Holliss, and two others, Daniel and Tom. To the surname of the former we have no clue, but the latter appears to have been a certain Tom Light, who is possibly the same person as the L—— of whom Bransby Cooper makes frequent mention. L—— had been a gentleman's servant who served seven years in the hulks off Portsmouth for stealing plate-glass from the windows of carriages. On his release he joined the resurrectionists, but was found to be so unreliable that he was compelled to leave the gang and become a horse-keeper, and finally drove a hackney-cab about London.

Another branch of the trade was that of the receiver or middleman, who disposed of the bodies raised by others and himself never took any part in the exhumation. Amongst others were White, a Scotchman, who was in collusion with Naples in his grave-digging days in Spa Fields, and a Jew named Michael Mordecai to whom a curiosity shop served as a cloak for a more lucrative trade in bodies.

R. M. W.

(To be continued.)

The Treatment of Sub-Coracoid Dislocations of the Shoulder Joint.

Dislocation of the shoulder is a very common injury; the most frequent variety is the sub-coracoid, in which the head of the humerus is forced through the lower part of the capsule and is displaced inwards and slightly downwards, so that it rests on the anterior aspect of the neck of the scapula. The sub-clavicular variety of dislocation—a comparatively rare form—in which the head is displaced further inwards so as to rest beneath the clavicle, is very similar to the sub-coracoid; the greater displacement of the head of the humerus in the former probably depends upon the position of the arm at the time of the injury, and to the direction of the violence.

Reduction of the common form of dislocation is usually easy. The methods commonly employed are either (1) Kocher's method of manipulation. (2) Direct traction, or (3) Direct traction with the heel in the axilla. While one of these methods is usually quickly successful, especially when the patient has been anæsthetised, every now and then cases are met with which cannot be reduced by the above-mentioned methods, even after a thorough trial with the patient fully anæsthetised. In hospital patients, dislocations of the shoulder are usually reduced in the surgery, and they are then treated as out-patients. When attempts at reduction are not successful, they are admitted for further treatment as in-patients.

For some time past I have treated these more difficult cases in the following way:—The patient is fully anæsthetised, either on a couch or on the ordinary operating table. When the muscles are relaxed an assistant firmly grasps the forearm while the surgeon gets a firm hold of the arm just below the axilla. When, as is usually the case, the patient is a big muscular man, both hands must be used for this purpose or a towel may be rolled up to form a sling which is looped round the arm, the surgeon getting a good grip of both ends of the loop. The first assistant applies steady traction to the dislocated limb in a direction parallel to the long axis of the patient's body; the surgeon at the same time steadily pulls the arm outwards while a second assistant or the anæsthetist, with a hand in each axilla, counterbalances the pull of the first two. The traction by all three is

made steadily and without jerking. The head of the humerus usually slips back at once into the glenoid cavity with the typical click.

I have now tried this method in about ten cases, all hospital in-patients. In all, attempts by the other methods had been made without success, either within the hospital or before admission. In several more than one attempt at reduction had been made under general anæsthesia. In every case reduction was immediately effected by the method described above. The only case in which it was not successful was one of those very rare cases of supra-clavicular dislocation which was eventually reduced by steady traction alone.

In all cases a radiographic examination was made to ascertain the position of the head of the bone, and to make sure that, in addition, there was no other injury such as a fracture of the neck of the humerus.

I have heard it urged as an objection to this method that two assistants are necessary, thus rendering it difficult of application in country practice, or in an emergency when two assistants cannot be found. In answer to this, it may be pointed out that the two assistants may be quite unskilled. Where the surgeon is called upon to treat such a case single-handed, he might himself administer the anæsthetic. A nurse, or even a friend of the patient, might apply traction to the forearm, and another attend to the counter-extension. When the patient is anæsthetised the surgeon could himself draw the upper arm outwards—the only part of the manipulation which calls for any special skill.

I would not suggest that this method should, in any sense, displace the simpler methods of reducing a dislocated shoulder, but the simplicity of the method and its success, in what must be regarded as difficult cases, lead me to recommend it, at any rate, in cases where the usual methods have failed.

PHILIP TURNER.

Change of Address.

T. Evans, M.D., from Milford House, Aberayron, to Llysowen, Grange Street, Port Talbot.

F. Collar, M.R.C.S., L.R.C.P., to Kismayu, British East Africa.

P. J. Monaghan, M.B., B.S., from Hammersmith Infirmary, to Somerset Hospital, Cape Town.

G. T. Foster-Smith, M.B., B.S., from Guy's Hospital, to 63, Shubra Road, Cairo, Egypt.

Alan H. Todd, M.B., B.S., B.Sc., F.R.C.S., to 26, St. Thomas's Street, S.E. *Telephone* Hop. 60.

G. Maxted, M.D., B.S., to 26, St. Thomas's Street, S.E. *Telephone* Hop 60.

O. C. H. L. Moll, from 28, Jeffery Street, to 8, Kingswood Villas, Gillingham, Kent.

F. G. Lloyd, from Guy's Hospital, to Queen Charlotte's Lying-in Hospital, Marylebone Road, W.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—ED., G.H.G.]

Spinal Anæsthesia at Guy's.

DEAR SIR,—I have previously thought of writing to you on this subject, but I felt diffident of anything which might appear to be critical of the lethargy of Guy's as regards spinal anæsthesia. Soon after leaving Guy's I was fortunate enough to see some of Mr. Tyrrell Gray's work, and was struck that he, and some of his colleagues at Great Ormond Street, used spinal anæsthesia almost as a routine for acute abdominal operations in children. Moreover, I was struck with the tremendous advantages of spinal anæsthesia in this class of case, when the spinal injection was carried out by an expert.

Of course, if any general anæsthetic has to be administered as well, many of the advantages of spinal anæsthesia are lost, and the spinal anæsthetic itself can hardly be termed a success when such a course is necessary. Perhaps I may be excused if I jot down, what seems to me, to be the two chief advantages of spinal anæsthetics:—1. Lessening of shock. 2. Complete relaxation of abdominal walls, resulting in increased facility and rapidity of operation.

The shock is certainly less than with a general anæsthetic. Moreover, once the child is anæsthetised, a skilled person is not monopolised by the anæsthetic, but can, if necessary, assist the surgeon. In emergencies, where professional help cannot be obtained, the anæsthetic and the operation could even be carried out by the same person. The relaxation is complete, far greater than is obtainable with a general anæsthetic, and, moreover, any straining is absent. The resultant shortening of the duration of the operation is great and important.

Hoping to hear more of spinal anæsthesia at Guy's,—I am, dear Sir, yours faithfully,

The Old College, Petersfield. W. T. CHANING PEARCE.

The Targett Memorial.

Mrs. Targett desires to convey her heartfelt thanks to all those members of Guy's Hospital who have so kindly given enduring expression to their feelings of respect and affection for her late husband, by placing in All Souls' Church, Langham Place, the beautiful Memorial Tablet, which was unveiled on the 1st instant, by Charters Symonds, Esq.

Extra-Uterine Gestation.

CLINICAL LECTURE BY HAROLD CHAPPLE, M.C.

GENTLEMEN,—During the last few weeks I have had under my care in the wards some cases of extra-uterine gestation, and I thought I could not do better than bring them again to your notice this afternoon, because they provide excellent examples of one of the most serious conditions associated with pregnancy. Serious, because it is almost always fatal to the child, and frequently disastrous to the mother. It is not at all a rare condition, and any one of you might at any time be called upon to diagnose and treat a case of this sort, and the patient's life will frequently depend upon your ability to do so.

I am most anxious to have a talk with you that may prove of some practical help, and I think I shall do that best by avoiding the introduction of all those portions of the subject that are open to discussion, and by omitting from our consideration, at any rate for the present, the rarer types of extra-uterine gestation, and by bringing before you the essential facts of two actual cases which are quite typical of this condition, in order to remind you how a diagnosis may be arrived at, and what is the most suitable treatment.

CASE 1.—A married woman of 35, who had had one child nine years previously. She had since been in apparently good health.

When first seen by her doctor her last period was three weeks overdue and came on with pain which was much more severe than usual. Three nights later she had a violent attack of pain referred to the left iliac fossa. Her doctor examined her but could find no cause, and the pain was relieved by a quarter of a grain of morphia. Next day she was better, but on the following day she had another attack of abdominal pain and vomited several times. The pulse was now 120. The next day another attack of pain; pulse, 120; and temperature, 100° F. She was again examined by her medical attendant and he now detected a lump in the left fossa and she was sent up to hospital. Her bowels had acted by enemata. On admission her temperature was 101° and pulse 128, and she was in great pain. There was tenderness over the lower abdomen but no rigidity. On vaginal examination one felt a large mass filling the left fornix and the Pouch of Douglas. It was very tender, was fixed, and of softish consistence.

CASE 2.—Was an unmarried woman of 21, whose periods had always been quite regular, and lasted two to three days. A month previous to admission, when her period was four days overdue, she was suddenly seized with left-sided abdominal pain and vomiting. Shortly after this attack she commenced a slight vaginal hæmorrhage, and four days after the pain began she passed a "membrane" per vaginam. She was kept in bed for a fortnight, during which time she had several attacks of pain, which later became generalised and not referred to any particular region.

She was allowed to get up at the end of the fortnight as the bleeding had then subsided, but this had the effect of immediately bringing on the hæmorrhage again.

On admission she looked ill and was very anæmic. The lower part of the abdomen was slightly prominent and did not move on respiration. On palpation the left side was extremely tender, and a smooth lump could be felt in the left iliac region rising from the pelvis. Vaginally, a smooth, firm, but softish mass was made out that was continuous with that felt in the left fossa. The pulse was 116 and temperature 100·4° F. There was a characteristic darkish red vaginal hæmorrhage. This was a very interesting case in that she had been sent up with the diagnosis of pelvic peritonitis, with membranous dysmenorrhœa and salpingitis, the possibility of pregnancy not being suspected.

I have read you these two histories because they are absolutely typical cases in which both the diagnosis and treatment were obvious, and the condition in each case was confirmed by operation.

First of all then—what is an extra-uterine gestation? It is, as the name implies, a pregnancy in which the developing ovum is arrested outside the cavity of the uterus, and this may occur at any point between the Graafian follicle and the uterine cavity.

The bulk of the evidence of recent experiment points to the fact that the ovum is normally fertilized in the Fallopian tube, and then finds its way into the uterine cavity and soon imbeds itself into its decidual lining. In the case of an extra-uterine pregnancy, the passage of the developing ovum is for some reason arrested, and it goes on growing at the site of its arrest.

By far the most common place for these phenomena to take place is in the Fallopian tube,

and I therefore propose to chiefly consider this condition this afternoon. But before passing on to an account of the symptoms caused by this, we must, in order to get a clear grasp of the subject, first pause to consider its anatomy.

The pregnancy may be arrested and develop anywhere along the tube in its interstitial, isthmic or the ampullary portions. The first condition is rare, but the other two are common enough. The developing ovum being arrested in either of these portions, rapidly burrows through the epithelium by the action of its trophoblasts and comes to lie in the muscular wall of the tube, and is surrounded by a pseudo-capsule. The uterus itself undergoes considerable hypertrophy, and its endometrium becomes changed into the decidua that is almost identical with that of a normal pregnancy. This decidual reaction is very scanty in the tube itself, and not nearly so well marked as in the uterus.

The placental development is identically the same as in a normal pregnancy, the different sequel being chiefly due to this scanty decidual reaction, so that the chorionic villi are soon to be found just under the peritoneal covering of the tube. Thus we have to consider a developing ovum lying in the muscular wall of the tube between the displaced lumen of the tube itself and the peritoneal cavity, and surrounded by an artificial capsule. It is not a matter for wonder that in this precarious condition, as development proceeds, something of a dramatic nature shortly takes place.

We are not introducing to-day unusual conditions, so that there are two possible fates for a developing ovum thus placed. It may rupture throughout the wall of the tube or into its lumen. In the former case it may rupture into the general peritoneal cavity, or more rarely between the layers of the broad ligament. In the latter event which is much the more common a tubal abortion will be the result, and this may pass out through the fimbriated end of the tube into the Pouch of Douglas, or, as is much more frequently the case, the abortion may be incomplete, and the products remain in the tube, in which case hæmorrhage continues to take place. If the hæmorrhage be moderate in amount and the ovum remains in the tube. it becomes surrounded with blood and a tubal mole is formed.

What will be the signs and symptoms by which this condition is to be recognized? There will usually be no symptoms whatever before the occurrence of abortion or rupture, and the patient will be quite unaware of the gravity of her condition, and it will only be recognized if a vaginal examination were made for any reason. When rupture or abortion takes place, definite symptoms, &c., will be present. These events are most likely, on the average, to take place about the sixth week, so that our first sign is *amenorrhœa*. There are three types of this to be borne in mind—

1. An overdue period. This should always, in a woman previously regular, raise the question of an ectopic pregnancy. The length of time that it may be overdue will vary from a few days upwards.

2. An elongated period, in a woman previously regular, should always raise the question of ectopic.

3. Before the next period comes on the ectopic may rupture, so that there will be no history of amenorrhœa.

Abdominal pain.—In a case of rupture this may be extremely sudden and severe followed by collapse. In cases of tubal abortion the pain is severe, spasmodic, and in attacks separated by an interval of time. After the first attack it is probably due to repeated hæmorrhages, the blood escaping from the fimbriated end of the tube into the general peritoneal cavity.

Vaginal hæmorrhage.—This does not as a rule occur at once. It is usually of a brownish-red nature and not profuse. It is occasioned by the death of the fœtus and the subsequent shedding of the decidua from the uterus. This decidua may be passed in small pieces or as a complete cast of the uterus.

A pelvic lump, which is typically unilateral. It is accompanied usually by a collection of blood clot in the Pouch of Douglas, so that a softish lump is detected posterior to the uterus and in connection with the lump in one or other fornix. It yields somewhat to gentle pressure. It may be extremely tender. It is well to remember that in cases of rupture there is not necessarily a definite lump to be felt, but the Pouch of Douglas is found distended with free blood, which has not yet clotted.

Again, the abdomen need not be rigid at all. I have opened the abdomen on several occasions to find many ounces of free blood with not the least sign of rigidity.

In the cases of abortion the temperature may be raised to 101° F. or thereabouts, and this is due to the absorption of serum from the blood in the pelvis.

With regard to the differential diagnosis, the cases of tubal rupture and abortion present quite different clinical pictures.

In tubal rupture, which is more likely to take place in the isthmic variety, the picture is that of an acute abdomen. In a married woman, especially if her period be overdue, the history of sudden abdominal pain, followed by collapse and the signs of loss of blood should always suggest a ruptured ectopic. It will be recognized at once, when the abdomen is opened, by the presence of free blood in the peritoneal cavity. The history of a short amenorrhœa followed by the onset of vaginal hæmorrhage with unusually severe abdominal pain and the presence of a pelvic lump should always raise the question of a tubal abortion. By far the most difficult condition to distinguish this from is a salpingitis, and it may be necessary before the distinction can be definitely made to explore the Pouch of Douglas, when the discovery of blood clot or pus will differentiate the conditions.

With regard to the treatment an extra-uterine should be removed as soon as it is diagnosed. In the cases of rupture this is obviously the only thing to do. In our experience palliative treatment is most unsatisfactory in cases of tubal abortion.

We have had in Queen several patients that have been watched, and kept in bed for two or three weeks to find a fresh attack of pain and hæmorrhage as soon as the patient has got about again, and there is always the risk of sudden rupture. There is still in the ward a case whose ectopic was left and suddenly became acutely infected with Bacillus Coli four weeks after admission and required removal.

It is wisest if possible to leave the corresponding ovary, and this can be done more easily in the isthmic rather than in the ampullary type of case. This is particularly necessary to bear in mind, as I have seen, in the last few months, five cases in which both tubes have been affected in succession. It is well to remember that there have been many cases in which, after the removal of one tube, the woman has subsequently gone through a normal labour.

It has been suggested that the affected tube should be laid open, its contents removed and its lumen restored. It does not appear at all likely that such a tube will subsequently function, although the readiness with which the Fallopian tube will restore its lumen is very remarkable. In many cases the condition of the patient would not allow of the adoption of this method, and the removal of the tube is the only course. If the circumstances are very much in your favour this conservative method may prove to be of service.

Case of Acute Intussusception with Passage of Normal Motions.

Margaret O'C., aged 3, was admitted into Clinical on October 21st for vomiting and abdominal pain. On the morning of Sunday, October 19th, she was noticed to be crying. That afternoon between 3 and 4 o'clock she complained of pain in the abdomen, and she continued to be in pain, with intervals of quiet, all Monday and Tuesday morning. She was several times sick, the vomit being green; her bowels were open three times on Monday and once on Tuesday morning, the motions being brown in colour and well formed. There was no blood in the stools or the vomit at any time. She was seen at Out-Patients about 11 a.m. on Tuesday morning, a bright girl, lying easily with a normal temperature, and pulse of about 100. She was not crying, but once or twice she drew up her legs and writhed about, but did not appear in great pain. She vomited once, the vomit being a bright green and containing no food.

On examination the abdomen was moderately distended; it was supple, but rather tender. Palpation revealed a tumour lying across its upper part, corresponding in position to the transverse colon, and suggesting this viscus distended with gas or some soft material. It was tender, and palpation appeared to set up a griping pain, so that the abdomen was made rigid and the legs drawn up. Tenderness was most marked in the left hypochondrium. A prominence corresponding in position to this tumour could now and then be seen just above the navel. By cross illumination waves of peristalsis were occasionally seen passing along it from right to left. The rectum was rather ballooned and full of fæces; nothing abnormal was felt in the lumen, and no blood appeared on the finger.

The condition of the child and the passage of normal motions seeming to negative the diagnosis of intussusception, she was taken in and put to bed, while an hourly pulse was taken. This showed: 12 noon, 112; 1 p.m., 120; 2 p.m., 128; 3 p.m., 140; 4 p.m., 148; 5 p.m., 128; 6 p.m., —; 7 p.m., 112; 8 p.m., 116. During this time the abdomen was too tense for the tumour to be felt; as, moreover, the child was asleep and did not seem in much pain, while the pulse rate was falling, an enema was given at 7.30 p.m., and half an hour later a well-formed motion was passed containing no blood. Merely as a last precaution a little chloroform was administered.

The tumour could now be easily felt and traced across the abdomen into the left hypochondrium, where it seemed to turn downwards and was lost. Per rectum nothing was felt, but another normal stool was passed during the examination.

The abdomen was now opened and an intussusception was found occupying the transverse colon as far

as the splenic flexure. This was readily reduced with only gentle manipulation, and was found to be of the ileo-cæcal variety. The incarcerated gut was shiny and absolutely normal in colour, showing no evidence of inflammatory change or interference with its blood supply. The appendix was quite remarkably long. The wound was then sewn up and the patient made an uninterrupted recovery and is now in splendid spirits.

Intussusception is the commonest surgical abdominal condition in children in the first few years of life, and is nearly always of the acute variety, with vomiting, collapse, griping pains, tenesmus, and the passing of blood and mucus per rectum in place of fæcal matter. Chronic intussusception in children is well recognised and is discussed in all text-books on the subject, but its occurrence at this age is very infrequent, and those cases which run a chronic course are marked by absence not only of constipation, but of any marked degree of pain or vomiting, so that they are not usually recognised till the condition has become well advanced. Dr. Goodhart in his book, "Diseases of Children," pages 155 et seq., says, "chronic intussusception is extremely rare, and when it does occur it is almost always in children not less than two years of age. . . . But none the less it is worth while to remember that an intussusception may exist without any constipation, without the passage of any blood or mucus, and, indeed, without any characteristic symptoms of any kind."

The present case showed several points of interest. Firstly, it was not a typical chronic case. The sudden onset of symptoms, the recurring attacks of griping pain, the obstructed type of vomiting, and the rising pulse rate on admission all suggest an acute attack; the occurrence of visible waves of peristalsis show that the colon was making efforts to pass on the invading portion of gut. Yet, throughout, the motions were normal in colour and consistence and contained no blood. Secondly, the difficulties in diagnosis were considerable. In addition to the atypical history, the tumour when felt was much softer than is usually the case with an intussusception, and after admission it was impossible to feel it at all; when, finally, an anæsthetic was given it was drawn down from under the costal margin. An additional sign which might have been of value, the abnormal emptiness of the cæcal region, was not given, for something which appeared to be the cæcum was felt in the right iliac fossa. Again, the complete absence of adhesions or any signs of inflammatory change after a history extending considerably over 48 hours is most remarkable. Lastly, the mother tells us that a year ago she had an exactly similar attack during which she had repeated attacks of colicky pains, and vomited green matter, the whole condition passing off in a day or two without treatment.

On this history it seems very probable that she was then suffering from a similar intussusception which underwent spontaneous reduction.

I am indebted to Dr. Hale White for his permission to publish these notes. W. H. O.

Pupils' Physical Society.

A Clinical Meeting of the Society was held in the Clinical Theatre and Wills Library on Saturday, November 8th, Mr. E. S. Taylor in the chair.

Mr. E. P. Poulton gave a demonstration of an easy clinical method of estimating the alveolar pressure of CO_2, and gave figures from the investigation of cases of diabetes, illustrating the fact that a fall of the alveolar CO_2 may be the first indication of the onset of coma in this disease.

The following gentlemen showed and described cases:

Mr. C. Sherris: Bilateral endarteritis in the internal capsules leading to double spastic hemiplegia.

Mr. C. P. Symonds: Gummatous pancreatitis, a patient on whom, at laparotomy four years previously, a diagnosis of inoperable carcinoma had been made.

Dr. H. C. Mann: Late rickets in a child of eight, with marked sabre-blade deformity of the tibiæ.

Dr. H. C. Mann: Fibroid lung, following a chronic fœtid bronchitis successfully treated with staphylococcus aureus vaccine. Dr. Mann explained that vaccine treatment was rarely possible in these conditions owing to the mixture of infection. In this case it was adopted only because on repeated bacteriological examination of the sputum the same organism was found in pure culture.

Mr. H. C. Richards: Paralysis following dislocated humerus, thought to be due to ruptured nerve-trunks.

Mr. Broster: Primary lateral sclerosis. There was a questionable nystagmus: it was pointed out that if this was present the diagnosis would probably be changed to disseminated sclerosis, though the pathology of the two conditions differed only in the distribution of the lesions.

The room was very full, forty members being present. The discussion of the cases was, perhaps, unduly confined to qualified men, but possibly for that reason was even more instructive than usual.

Gazette Special Pathologist.

A. H. B., St. Albans.—This specimen is muco-purulent in character, and tubercle bacilli are present in considerable numbers.

H.L., Manchester.—This is a malignant growth, composed of branching solid epithelial alveoli in a fibrous stroma. Its general structure is that of a spheroidal-celled carcinoma, and we should expect it to be a secondary growth. PATHOLOGIST.

Pass List.

Royal College of Surgeons of England.

LICENCE IN DENTAL SURGERY.

FINAL EXAMINATION, NOVEMBER, 1913.

Parts I. and II.

*Alabone, L. | *Cohen, L. C.
*Oliver, C. H.

Part I. only.

Cole, A. H. | Johnson, S. E.
Corke, H. C. | Pearson, M.
Cutts, G. L. | Pickett, R. J.
Edwards, H. J. | Stebbings, J. M.
Hammond Williams, W. C. | Wright, J. E.

Part II. only.

*Adams, S. | *McFarlane, P. S.
*Bradley, R. G. | *Montgomery, L. T.
*Brown, A. A. | *Palmer, J. S.
*Bulleid, W. A. | *Pitman, K. C.
*Camp, A. F. | *Rix, R. H.
*Cowell, R. G. | *Saunders, G. V.
*Edwards, C. H. | *Smith, H. L.
*Flooks, W. T. | *Staley, R. C. W.
*Fry, W. K. | *Stevens, S.
*James, H. G. | *Underwood, A. B. G.
*Johnson, E. E. | *Veale, R. M.
*Wright, L. D.

* Denotes completion of examination.

FIRST PROFESSIONAL EXAMINATION, NOVEMBER, 1913.

Mechanical Dentistry and Dental Metallurgy.

*Curtis, H. | *Wallace, F. H.
*Stebbings, H. V. | *Williamson, G. C.
*Thorn, H. L. | *Wright, J. A. S.

Mechanical Dentistry only.

*Allan, W. J. McB. | *Hill, J. J. Stirling.
*Bullpitt, C. M. | Hollington, J. J. L.
*Corke, T. D. | *Ordish, F. J.
*Debenham, L. S. | *Smith, S. Gordon.
*Dee, G. | *Van Schalkwijk, P. L.
*Duff, K. M. K. | Wallis, H.
*Wheldon, G. W.

Dental Metallurgy only.

Alcée, J. | *Dawson, E. A.
Barrand, H. J. | *Dean, A. C.
Batsford, J. F. | Dixon, L. H.
Browne, E. G. | *Duggan, H. C.
Cade, C. R. | *Henry, M. G.
Cross, L. H. | Sanders, S.
Southwell, C. S.

* Denotes completion of examination.

University of Cambridge.

Degree M.C. conferred.—H. L. Attwater.
Degree M.D. conferred.—H. L. Duke.

Final Conjoint Examination.

MIDWIFERY ONLY.

L. Muir-Smith.

The above name should have appeared in the last number of the GAZETTE, but was omitted owing to a mistake on the part of the Secretary of the Conjoint Examining Board in not including it in the list he sent to the Medical School Office.

Guy's Hospital Musical Society.

THE First Choral and Orchestral Concert of the session will be held on Friday, December 12th, at 8.15 p.m. in the Physiological Theatre. A very attractive programme will include: Cantata, "Sleepers Wake," Bach; "Soul of the World," Purcell; "How lovely are thy dwellings fair," Gipsy Songs, Brahms. The following soloists have very kindly offered their services—Miss Gladys Moger, Soprano; Mr. J. Stewart Wilson, Tenor; Mr. Clive Carey, Baritone.

Particular attention is drawn to the fact that there are a very few choral practices remaining before the concert. Members are reminded that they take place on Mondays at 5.15 p.m. and on Fridays at 8 p.m. in the Physiological Theatre.

Tickets, 2s. 6d. and 1s., may be obtained from either of the Secretaries.

H. Q. F. THOMPSON,
J. J. STERLING HILL,
Hon. Secs.

Papers by Guy's Men.

A. F. Hertz, M.A., M.D., F.R.C.P.: The Cause and Treatment of Certain Unfavourable After-Effects of Gastro-Enterostomy.—*Annals of Surgery*, October, 1913.

A. J. Hull, F.R.C.S., Major R.A.M.C.; Recurrence of Inguinal Hernia.—*Annals of Surgery*, October, 1913.

John D. Malcolm, C.M., F.R.C.S. Edin.: On the State of the Blood-vessels in Shock.—*Lancet*, November 8th, 1913.

F. Gowland Hopkins, M.A., M.B., D.Sc., F.R.S.: Diseases Due to Deficiencies in Diet.—*Lancet*, November 8th, 1913.

A. H. Tubby, M.S., F.R.C.S.: Some Additional Experiences of Nerve Surgery.—*Lancet*, November 8th, 1913.

A. H. Tubby, M.S., F.R.C.S.: Dupuytren's Contraction Successfully Treated by Open Incision and (Thiosinamin) Fibrolysin.—*British Medical Journal*, November 8th, 1913.

Hugh Barber, M.D.: Chronic Interstitial Nephritis in Children.—*British Medical Journal*, November 8th, 1913.

Sir George Savage, M.D., F.R.C.P.: Discussion on Sleep, and the Treatment of Sleeplessness.—*British Medical Journal*, November 8th, 1913.

G. D. Eccles: A Case of Bilateral Gangrene of the Legs following Confinement.—*British Medical Journal*, November 8th, 1913.

C. M. Wenyon, M.B.: The Morphology of the Intestinal Amœbæ of Man.—*British Medical Journal*, November 15th, 1913.

Recent Additions to the Wills Library.

BY PURCHASE.

*Bennett's Science and Practice of Dental Surgery.

Bowlby and Andrews' Surgical Pathology, 6th edition, 1913.

British Journal of Surgery, vol. 1, 1913, and in continuation.

Bury's Diseases of the Nervous System, 1912.

Cunningham's Text-book of Anatomy, 4th edit., 1913.

Cushny's Text-book of Pharmacology, 5th edit., 1910.

†Ergebnisse der inneren Medizin und Kinderheilkunde, vols. 10 and 11, 1913.

Galabin and Blacker's Practice of Midwifery, 7th edition, 1910.

Garrod, Batten, and Thursfield's System of Children's Diseases, 1913.

Gray's Anatomy, 18th edition, 1913.

Gulland and Goodall's The Blood, 1912.

Guthrie's Functional Nervous Disorders in Childhood, 1909.

Haldane's Mechanism, Life and Personality, 1913.

Herman and Maxwell's Diseases of Women, 4th edit., 1913.

Hewlett's Manual of Bacteriology, 4th edition, 1911.

Hopewell-Smith's Introduction to Dental Anatomy and Physiology, 1912.

Keen's System of Surgery, vol. VI., The Newest Surgery, 1913.

†Krause's Surgery of the Brain and Spinal Cord, 3 vols., 1910-1913.

†Mayo Clinic. Collected Papers by the Staff of St. Mary's Hospital, Mayo Clinic, Rochester, 1912, 1913.

†Oppenheimer's Handbuck der Birchemie des Menschen und der Tiere. IV., 1ter Halfte, Gaswechsel und Stoffwechsel, 1911; IV., 2ter Halfte, Energiewechsel und Stoffwechsel, 1910; Erganzungsband, 1913.

Pembrey and Ritchie's Text-book of General Pathology, 1913.

Poynton's Heart Disease and Thoracic Aneurysm, 1907.

Poynton and Paine's Researches on Rheumatism, 1913.

Short's The New Physiology in Surgical and General Practice, 2nd edition, 1913.

Vincent's Internal Secretions and the Ductless Glands, 1912.

PRESENTED.

Barbour's Anatomy of Labour, 2nd edition, 1899. By Mrs. Galabin.

Bland-Sutton's Position of Abdominal Hysterectomy, 1909. By Mrs. Galabin.

Boas' Diagnostik und Therapic der Magenkrankheiten, 2 Bande, 5te Anflage, 1903-07. By Dr. A. F. Hertz.

Bramwell's Diseases of the Heart, 1884. By Mrs. Galabin.

Browne's Religio Medici, 6th edition, 1669. By Mr. J. Copland.

Calendar of the Royal College of Surgeons of England, 1913. By the Council of the R.C.S.

Cancer Hospital Research Institute Selected Papers, vol. I., 1913. By Dr. Alex. Paine.

Catalogue (MS.) of Mr. T. E. Bryant's Museum, Kennington, 1828. By Dr. G. Newton Pitt.

Doran's Eighteenth Century Obstetric Forceps (Reprint). By Mr. Alban Doran.

Edward Jenner (Cutting from the European Magazine, September, 1804). By Sir George Turner.

Eyre's Bacteriological Technique, 2nd edition, 1913. By Dr. J. W. H. Eyre.

Finnemore's Pharmacy and Materia Medica for Nurses, 1913. By Mr. H. Finnemore.

Fremantle's Health and Empire, 1911. By Dr. F. E. Fremantle.

Fremantle's Impressions of a Doctor in Khaki, 1901. By Dr. F. E. Fremantle.

Geddes' Statistics of Puerperal Fever, 1912. By Mrs. Galabin.

Grant's Short Account of a Fever and Sore Throat which began to appear in and about London in September, 1776; in a Letter to Dr. William Saunders, 1777. By Dr. G. Newton Pitt.

Gray's Anatomy, 16th edition, 1905. By Mr. J. Copland.

Hooker's Chloride of Lime in Sanitation, 1913. By the Hooker Electrochemical Co., New York.

Jordan's Intestinal Stasis, 1913 (and 7 other Pamphlets). By Dr. Jordan.

Journal of Physiology (as published). By Dr. A. F. Hertz.

Kirkpatrick's History of the Medical School in Trinity College, Dublin, 1912. By Mr. Charters Symonds.

Latham's Pulmonary Consumption, 3rd edition, 1907. By Mr. J. Copland.

Laws of the Physical Society, held at Guy's Hospital, 1820. By Mr. C. L. F. Leipoldt.

Lee's Some Acute Visceral Inflammations, 1904. By Mrs. Galabin.

Letheby's Report on the Condition of the Cow-houses within the City of London, 1856. By Sir George Turner.

Medical and Surgical Reports of the Episcopal Hospital, Philadelphia, 1913. By Dr. Astley Paston Cooper Ashhurst.

Metchnikoff's Comparative Pathology of Inflammation, 1893. By Mrs. Galabin.

Norbury's Public Care of the Insane and Mentally Defective, 1912. By Dr. Frank P. Norbury.

Osler's Aequanimitas, 2nd edition, 1906. By Mr. J. Copland.

Papers set for the Examinations for the Diploma in Public Health, R.C.P.S., 1909, 1910, and 1911. By Dr. King Browne.

Practitioner (as published). By Dr. A. F. Hertz.

Proceedings of the Royal Society of Medicine, vols. 1-6, 1907-1913. By Dr. J. Batteson.

Report of the Pellagra Commission, State of Illinois, 1912. By Dr. F. P. Norbury.

*Sanctioned by Library Committee to be added when published.

†For Davies-Colley Collection.

Sawyer's Insomnia, 2nd edition, 1912. By Sir James Sawyer.

Schlesinger and Gardner's "Mactreth," 1912. By the Authors.

Senter's Outlines of Physical Chemistry, 3rd edition, 1912. By Dr. H. C. Cameron.

Senter's Text-book of Inorganic Chemistry, 1911. By Dr. H. C. Cameron.

Simon's Report on the Sanitary Condition of the City of London, 1848-49. By Sir George Turner.

Smith's Lectures on Botany (MS.), 1796. By Dr. G. Newton Pitt.

Stevens' Diseases of Women, 1912. By Dr. T. G. Stevens.

Studies in Cancer, vols. 1 and 3, 1913. By the George Cracker Special Research Fund.

Taylor's Catalogue of the Library of the Society of Apothecaries, 1913. By Dr. W. Bramley Taylor.

Thorne's Nauheim Treatment of Diseases of the Heart, 4th edition, 1913. By Leslie T. Thorne.

Thresh and Porter's Preservatives in Food, 1906. By Mr. J. Copland.

Transactions of the Pathological Society, vols. 27-58, 1876-1907. By Dr. J. Batteson.

True Copy of the Last Will and Testament of Thomas Guy, Esq., late of Lombard Street, Bookseller: containing an Account of his Publick and Private Benefactions, 1725. By Mr. R. M. Wingent.

Copy of the Last Will and Testament of Thomas Guy, Esq., 1725. By Mr. R. M. Wingent.

Ditto. ditto, 1732. By Mr. R. M. Wingent.

Wanklyn's Administrative Control of Small-pox, 1913. By Mr. H. Millett.

Williams' Roentgen Rays in Medicine and Surgery, 1903. By Dr. Francis H. Williams.

Wingent's Historical Notes on the Borough and Borough Hospitals, 1913. By Mr. R. M. Wingent.

Reviews, etc.

Clinical Electrocardiography. By Thomas Lewis, M.D., D.Sc., F.R.C.P. (Shaw & Sons, London.)

In this book Dr. Lewis has given a short account of the electrocardiograph and the information to be gained from its use. The book opens with a chapter on technique containing many details, which will be found useful by anyone wishing to obtain a practical acquaintance with the instrument. The later part deals with the physiological electrocardiogram and the deviations from the normal found in pathological conditions, the different types of irregularity being described and their method of production briefly indicated without superfluous theoretical discussion. The views on heart disease have been so modified by the work done in the last ten years that some knowledge of it is essential both to the practitioner and to students presenting themselves at the higher examinations. The book will be invaluable to anyone wishing to study this branch of medicine, for it contains within a small compass all the more important results of recent cardiac research. The style is clear and concise and the illustrations excellent.

Studies on the Influence of Thermal Environment on the Circulation and the Body-heat. By Edgar Lyth, M.B., M.R.C.S. (Messrs. John Bale, Sons & Danielsson, London.) Price 2s. 6d. net.

This book is an account of observations and experiments conducted by the author and makes no attempt to deal with the work of others.

The quantities determined were the rectal temperature, abdominal cutaneous temperature, frequency of the pulse, and arterial blood pressure, both maximum systolic and mean diastolic. These were determined with Oliver's hæmodynamometer which gives results which are considerably higher than those obtained with the modified Riva Rocci apparatus and can therefore only be regarded as comparative. The product of the sum of the two pressures and the pulse frequency gives a quantity, which is called a "pardiobar," and is supposed to form a measure of the work done by the heart. The assumption involved, that the output per beat of the heart is a constant when the rate varies, is not in accordance with recent work. The results may be summarised as follows: External warmth raises the temperature of the skin, causes the blood pressure to fall, and quickens the pulse. Moderate cold has the opposite effect, but a greater degree of cold has a stimulating action and quickens the pulse. Air in motion, when it is definitely cooler than the skin, quickens the pulse. So does the water of a bath when it is stirred provided it be at a different temperature from that of the skin, either hotter or colder. The rectal temperature frequently changes in the opposite direction to the cutaneous temperature. Thus, a cold bath cools the skin markedly, but from the muscular activity that results there is usually a rise of rectal temperature, and external warmth if great enough ultimately causes a rise of rectal temperature, but its first effect when the skin is cool to start with is to cause a fall of rectal temperature as the circulation through the skin begins to increase. These and other results are clearly set forth by means of charts.

In conclusion the author gives a short account of his views of the physiology of these things, which is not very clear nor very adequate. In fact, the observations are scarcely comprehensive enough to justify publication in book form without reference to the literature of the subject.

Rugby Football.

GUY'S v. OXFORD UNIVERSITY.

It was very nasty at Oxford for this match on Wednesday, October 29th. A heavy wind and squalls of rain made things very unpleasant, and handling the ball, to say nothing of passing it, was very difficult. The ball was constantly dropped, and feet had to be resorted to on numerous occasions when in the ordinary way a determined run would have been the play. Oxford had a strong side out, Loudoun-Shand,

F. H. Knott, G. B. Crole, D. M. Bain, H. B. Moore, and other well-known University players making up a formidable XV.

Soon after the start a promising movement, for us, ended with Curle slipping up. Oxford pressed after this, but Guy's got relief by means of a free kick. Again Oxford became dangerous, and only the wet ball prevented the Varsity from getting close up. Passing neatly, they were well on the move until Loudoun-Shand fumbled. Millett then had his kick charged down, and Crole was only brought down within a few feet of the line. Guy's got on the move, but the passing, though well carried out, ended fruitlessly, and half-time arrived with no score.

A good deal of rather aimless kicking by Guy's took place on resuming, but soon Knott, Shand, and Crole were instrumental in getting well down for Crole to run in with a try. Knott tackled Rook, and Steyn was almost over, when Reid, the Varsity full-back, tackled him. Millett played a great game, and mainly by his defence and some fine tackling by Steyn and Harkness, Oxford were kept out till just on time, when a brilliant piece of passing, started by Rhodes and carried on till Crole was reached, saw that player just manage to throw himself over the line. No conversion followed, Oxford thus winning by 2 tries to nil. Team :—

GUY'S.—H. Millett (back); S. S. L. Steyn, C. L. Curle, A. H. Harkness, A. F. Rook (three-quarters); L. R. Broster, C. H. Medlock (halves); O. Parry-Jones, M. Tweed, A. Liebson, C. H. Laver, E. F. Llarena, A. L. Anthony, C. Gibb, G. F. Kidman (forwards).

REMARKS.—Millett played a great game. It was not much of a day for backs, so we must leave them out for this occasion. The forwards heeled much better and altogether more than held their own. They are fast training on to be a great pack.

GUY'S v. STREATHAM.

The weather turned out brilliantly fine for this fixture at Honor Oak Park on Saturday, November 1st. But there was a big attraction at Blackheath which somewhat took away from the usual Hospital following. Guy's were well represented and started off in very promising fashion; indeed, they rapidly established a comfortable lead of 8 points, the first 5 of which were obtained by Medlock goaling a try Parry-Jones gained by some good hand-to-hand passing, emanating, in the first place, from Rook who got away very smartly from the line out. Some very fine three-quarter play sent Medlock over with the second try about twenty minutes after the game had commenced, but after that the Hospital fell away. Broster tried very hard to get things going again. The forwards, of whom Parry-Jones was particularly good, played well, but the Streatham defence, aided by their halves getting frequently offside, an offence towards which the referee constantly turned his blind side, was very sound.

After half-time Harkness dropped a neat goal, and Pirrie got an unconverted try for the visitors. There the scoring ceased, and the remainder of the game was a hard forward scramble. Rook and Curle changed places, Rook coming into the centre position for which he is more fitted. Steyn did not get many passes the latter portion of the game, but as he had received a nasty knock on the knee, it is probable he was not very anxious for them. He is a player who, in the ordinary way, should be given the ball on every possible occasion. On Saturday he was very much watched. Final score:—Guy's, 1 goal 1 dropped goal 1 try, 12 points; Streatham, 1 try, 3 points. Team:—

GUY'S.—H. Millett (back); S. S. L. Steyn, A. F. Rook, A. H. Harkness, C. L. Curle (three-quarters); L. R. Broster, C. H. Medlock (halves); C. S. L. Roberts, O. Parry-Jones, M. Tweed, A. S. Liebson, C. H. Laver, A. B. Danby, E. F. Llarena, G. F. Kidman (forwards).

REMARKS.—One does not want to say much about the three-quarter line till it has played as above again, but in the first half Curle at centre was not taking or giving his passes well. Broster worked very hard indeed. The opposing halves were offside most of the afternoon and gave him a very trying time. Llarena tackled well. Tweed kicked too hard. Parry-Jones and Laver played exceedingly well.

GUY'S v. LONDON WELSH.

Without C. S. L. Roberts and A. H. Harkness the Hospital went on Saturday, November 8th, to Wandsworth to meet the London Welsh. Our contemporaries, in their anxiety to point out that the Welshmen were not at full strength, forgot to point out that we played without our best forward and captain.

Broster was very early in evidence, Tucker, the home full-back, being collared in possession, and for a time the Hospital pressed severely, Parry eventually punting well into Guy's territory. Medlock had a shot from a penalty, and then Curle followed up very smartly a high punt, and secured a try which Medlock easily put the extra points to. Llarena followed with a try which Medlock found impossible to add to. It was a rather easy score. Then came some very neat work by Steyn, who, on the right, had been doing excellent work. He got away nicely, and when hemmed in close on the line handed over to Broster who scored, Medlock finding no difficulty in placing a goal. As far as Guy's were concerned this was the end of the scoring. Though having a clear advantage of 13 points at half-time, the chances were the Hospital would increase their lead still further, especially as Steyn got possession frequently and always wanted much watching. But it was to the Welsh the next score fell. Humphreys, taking a drop and missing gaol, followed very quickly and dropped

on the ball for a try which Richards converted. Towards the end Guy's had several penalties awarded them, but no further scoring took place, the Hospital winning by 2 goals 1 try (13 points) to 1 goal (5 points). Team:—

GUY'S.—H. Millett (back); S. S. L. Steyn, C. L. Curle, A. F. Rook, R. Crook (three-quarters); C. H. Medlock, L. R. Broster (halves); O. Parry-Jones, M. Tweed, A. S. Liebson, A. B. Danby, C. H. Laver, E. F. Llarena, G. F. Kidman, D. M. Whitcombe (forwards).

REMARKS.—There was very little in the game that calls for special criticism. Millett, Broster, and Steyn played exceptionally well. The forwards were better from the line out, but there is still room for improvement in the tackling. They must try and go low, and just a little more "devil" is necessary in the rushes.

GUY'S v. LONDON IRISH.

The Hospital went to Wandsworth for the second time on Saturday, November 15th, on this occasion to meet the Irish, who share the Wandsworth enclosure with the London Welsh. Roberts was not playing, otherwise the team was at usual strength.

Play commenced with a strong diagonal wind blowing, and before long it was evident the referee was going to translate the rules very strictly; but he was most impartial in his decisions. Quite early a penalty against Millett in front of goal looked very ominous, but the kick just missed. Medlock had two shots from penalties at long range; good, but just unsuccessful. Then Steyn was penalised for something; the infringement was difficult to define. After this play settled down, and Steyn almost dodged through on the right. Broster, Harkness, and Curle came away subsequently in good style from their own 25. Curle cross-kicked, but nothing resulted. Liebson received from a line out, and feinting, made much ground; the ball subsequently was thrown to Steyn who was held close in. This was followed by a series of Irish rushes, till Medlock got through with a beautifully straight run, and reaching Callinan he punted, or tried to do so; unluckily the ball screwed off his foot, otherwise a try seemed certain. A good drop at goal by the same player was followed by Broster boring right through the scrum for a try too wide to convert.

The Irish forwards were all over us for some twenty minutes of the second half, during which time Duggan got a good try for them. He ought to have been tackled, but he is a strong, powerful runner and difficult to hold. Our forwards could not make headway at all. Callinan, the Irish full-back, was also fielding and kicking with great length and accuracy. It was Medlock and Broster who raised the siege. They both tackled and dribbled well and the former ran with great judgment, while Broster at all points of the game played splendidly. Just on time he put in a fine run which almost got a try. Steyn was lame the second half. Final score:—London Irish, 1 try (3 points); Guy's Hospital, 1 try (3 points). Team:—

GUY'S.—H. Millett (back); S. S. Steyn, A. F. Rook, A. H. Harkness, C. L. Curle (three-quarters); C. H. Medlock, L. R. Broster (halves); O. Parry-Jones, M. Tweed, A. B. Danby, A. Liebson, E. F. Llarena, C. H. Laver, G. F. Kidman, D. M. Whitcombe (forwards).

REMARKS.—The forwards are getting together nicely, but they had a bad time just after half-time in their own 25. They must exhibit more devil, shove harder and come through with the ball with more dash, and back up each other with all the vigour they can command. Both half-backs played exceedingly well. Neither centre was good at attack. They are too slow at present and do not give their wings much chance. Their movements are a little too obvious, and no one, wing or centre, seems to back Medlock up properly. Those fast straight runs of his are not well supported by the backs. Steyn and Curle had little to do. Millett tackled well.

Association Football.

GUY'S v. CARSHALTON.

SURREY SENIOR CUP—SECOND ROUND.

This game was played on Saturday, November 1st, at Honor Oak Park. We were not very punctual in starting; Carshalton's right back had not turned up, so we waited five minutes and then started without him. They did not seem to miss their man very much, and were soon attacking our defence, but found it safe. Our right wing found touch too often to make much headway with the ball, whilst our defence found some difficulty in coping with Carshalton's left wing, who put in some very dangerous centres. Coxon and Stebbings pressed hard to get through, but Williamson missed some chances by wasting too much time in getting started. Coxon's regular training during the week seems to have done him good, and he had very bad luck in not scoring from a long shot from the left; but later he made a good opening from which Stebbings easily scored. In endeavouring to stop a forward rush, Phillips handled the ball just outside the penalty area, and though they did not score from this, their centre forward soon after put in a very fine shot from a bouncing ball which gave Welton no chance.

In the second half the referee's whistle was more lively than usual, though few seemed to know what was amiss, including the referee himself, who more than once had to bounce the ball owing to the weakness of his decision. Neither side managed to score the deciding goal, and though we managed to keep the ball more or less in their half, once or twice they came dangerously near our goal. Welton, however, who was playing quite on the top of his form, cleared

each time. The game thus ended in a draw, so that a return match is necessary. Team:—

GUY'S.—F. E. Welton (goal); E. S. Phillips, J. Kyle (backs); A. E. Cooke, D. A. Bevis, L. Gill (half-backs); C. Williamson, S. J. Stebbings, A. C. M. Coxon, R. J. Pickett, R. Evans (forwards).

GUY'S v. EMERITI.

This game was played on Wednesday, November 5th, at Honor Oak Park. Emeriti arrived with two men short, so Kidman consented to play as a substitute. It was soon evident, however, that they sadly missed their two men, and though they pressed a little soon after the start, they were never really dangerous. Once or twice they got away, but their shooting was far too irregular to give Harrington any trouble. Guy's forwards soon got going, and Pearson was the first to score with a good shot into the corner of the net. Johnstone was the next to score by running right through with the ball. Williamson had bad luck in not scoring from a shot which bounced off the post.

In the second half the game deteriorated into a scramble round the Emeriti goal. It was good shooting practice for Guy's forwards, but otherwise the game more or less lacked interest. Pearson and Johnstone each added two more goals to the score, and Williamson, who put in some very fine centres from the wing, managed by a lucky shot to score through the goalkeeper's legs. Johnstone was also responsible for another goal which, however, was given offside. Thus the final score was: Guy's, 7 goals; Emeriti, 0.

GUY'S.—Harrington (goal); H. J. Bensted, E. S. Phillips (backs); N. Allan, L. Gill, A. E. Cooke (half-backs); R. Evans, M. Pearson, G. P. Lindsay, —. Johnstone, C. Williamson (forwards).

Hockey.

SEASON, 1913—1914.

AT the Annual Meeting of the Hockey Club held on Tuesday, September 30th, the following officers were elected: — President, Mr. Steward; Vice-Presidents, Mr. Fagge and Mr. Ormond; Captain, J. F. Venables; Vice-Captain, J. H. Parry; Joint Hon. Secretaries, R. W. P. Jackson and G. D. Gripper. Committee: L. A. Graham, O. G. Morgan, and C. R. Smith.

It was decided that this year a special effort should be made to obtain a suitable ground, and as such a one was reported to be available at Surbiton it was agreed unanimously that, although it was farther away than desirable, it should be procured.

It is, therefore, hoped that this year with our long list of fixtures and a definite ground on which to play our home matches we shall, when the Inter-Hospital Tournament arrives, be able to turn out a team that has been playing regularly together throughout the season. We are fortunate this year in being able to look forward to most of last year's team turning out regularly; we shall, however, sadly miss Bromley and Poulton from the forward line. We are, however, pleased to hear that Venables will be able to play regularly for us this season.

We cannot fail to record our gratification that the Blues Committee have now awarded members of the Hockey Team a Full Blue in place of the Half Blue previously granted.

The following were awarded a Full Blue:—L. A. Graham, J. H. Parry, L. Bromley, E. P. Poulton, C. Vincent-Brown, R. W. P. Jackson, C. R. Smith, H. N. Purdom, O. G. Morgan, G. D. Gripper, A. C. M. Coxon. Half Blues:—J. F. Venables, P. E. Jessop, B. Burnside.

GUY'S v. MALDEN.

This match was played on Saturday, October 18th, at Thames Ditton. This was our first match this season, a previous match having to be scratched owing to the state of the weather. During the first half the game was very even, Malden several times pressing strongly, although on only one occasion did they really look like scoring. Towards the end of the half, however, our forwards managed to get going, and gave us a lead of 1 at half-time.

In the second half, however, we had most of the game, and secured 3 more goals before Malden scored their only goal just before the whistle went. Team:—

GUY'S.—G. Deeks (goal); G. D. Gripper, G. Cutts (backs); L. Waghorn, R. W. P. Jackson, C. R. Smith (halves); J. H. Parry, P. E. Jessop, L. A. Graham, G. Waight, C. Vincent-Brown (forwards).

PAPERS RECEIVED.—Nursing Times, Hospital, St. George's Hospital Gazette, Magazine of London (Royal Free Hospital), School of Medicine for Women, Clinical Journal, New York State Journal of Medicine, Polyclinic, St. Bartholomew's Hospital Journal, Middlesex Hospital Journal.

Birth.

HIND.—On October 26th, at 20, Stamer Terrace, Stoke-on-Trent, to the wife of G. R. Hind, M.B., B.S., a daughter.

Marriage.

SYMNS—SOWTER.—On November 6th, at All Saints', Notting Hill, James Llewellyn Montfort Symns, B.A., M.B., B.C. Cantab., to Claire Hickling Dart Sowter, eldest daughter of John Sowter, of Derby.

Deaths.

KNAGGS.—On October 13th, at Cheltenham, Lieut.-Colonel H. Knaggs, retired Brig.-Surgeon, Army, aged 78 years.

ROBINSON.—On October 8th, suddenly, at Colombo, Morris de Lancey Robinson, M.D., B.S., D.P.H., aged 32 years.

G. T. M.

GUY'S HOSPITAL GAZETTE.

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Passim.

A FEW weeks ago a meeting of editors of the various Hospital Journals was held at St. Bartholomew's on the initiative of the editor of the "St. Bartholomew's Hospital Journal," to consider the suggestion that they might co-operate to some extent in the treatment of certain questions of interest to medical students.

The editors, or their representatives, from St. Thomas's, St. George's, Middlesex, London, St. Mary's, the Royal Free, Guy's and Bart.'s were present at the meeting, and they decided to meet periodically to discuss informally matters of general interest to the medical profession, and to the students in particular. It was felt and hoped that the current opinions of medical students would be more effectively dealt with by concerted action than is the case at present, when each small group lifts its small voice when and where it will, without reference to the other groups of London students. The subjects which at present seem to be worthy of special consideration are, firstly, the proposed changes in the University of London, and, secondly, the vexed question of the new anatomical terminology or B.N.A. (Basle Nomina Anatomica), as it is termed. We shall be glad to hear of other subjects from our readers which they consider should be treated by the students' journals collectively.

A FANCY DRESS BALL for Juveniles will be held in the Court Room (by permission of the Governors) on Wednesday, January 14th, 1914. A similar Dance was held in the Court Room two years ago and was a great success, the children in their fancy dresses making a charming scene. We have no doubt that the organizers will have equal reason to be pleased with themselves this year, and we wish them every success, especially in view of the excellence of their motive. The Ball is being organized by the Guy's Hospital Ladies' Association in furtherance of their project of permanently endowing a Cot in the Hospital, and the proceeds will go to the fund already raised for this object.

Those who intend to be present are advised to make early application for their tickets, as the number to be issued is strictly limited. Tickets, price Five Shillings each for Dancers, and also at the same price for Chaperons and Spectators (with the proviso that Fancy Dress is not necessary), may be obtained, together with any other particulars, from the Honorary Secretaries, Mrs. Philip Turner, 73, Wimpole Street, W., and Mrs. Cameron, 6, St. Thomas Street, S.E.

It is unnecessary to remind our readers of the near approach of Christmas. Indeed, in the Hospital here we are made all too well aware of it. From the sounds which proceed from the Junior Charity's Room about tea-time there is no doubt but that the Niggers have started practice. We understand that rag-time is not entirely debarred from their programme. Also we hear rumours from time to time of the Residents' Theatricals, which are also well on the way, we understand. Men in the Dissecting Room also seem to have their Christmas worries. We hear numerous anxious inquiries as to the date of the "Bones" Examination from men who "haven't even begun to read the skull yet."

And nowhere in the Hospital is one safe from the man with the collecting book. From each man, according to his appointment, are special dues exacted, but in addition there is one fund which has claims on all and sundry. This is the Landon Christmas Tea Fund. This fund was established nearly ten years ago by the late T. H. W. Landon, and has through its intrinsic merits continued to be a success ever since. As most of us know it aims at providing tea, entertainment, and a present for nearly 700 out-patient children on Christmas Day.

Subscriptions (2s. 6d.) will be gladly received by any of the following: the Out-Patient Officers, the Dental House-Surgeons, the Student Demonstrators, and Sister Out-Patients. Any man who will come up to Out-Patients on Christmas afternoon will feel that he has never spent half-a-crown to greater advantage before.

Messrs. Ash & Co. have again prepared a series of Christmas Greeting Post Cards, including views of the Front Gates, Nurses' Home, Clinical, Medical Buildings, Thomas Guy conferring over Plans of the Hospital, and Guy's Arms. The cards are very tastefully prepared and printed and should command a big sale. As an added stimulus to their circulation, we may add that through the generosity of Messrs. Ash & Co. the proceeds from their sale will go to the Hospital funds. They may be obtained from the Wills Librarian, or from Miss Smith in the Matron's Office.

This evening, Saturday, December 6th, the Physical Society hold their annual discussion. The subject chosen for this year is "The Treatment of Syphilis," and a very keen and interesting discussion is sure to be held. We advise every man in the wards who has not already made arrangements for to-night to turn up. He will not be disappointed. The meeting is at 8.15 p.m. in the College Smoking Room.

We would again remind our readers of the Musical Society's Concert, which will be held on Friday next, December 12th, at 8.15 p.m., in the Physiological Theatre. We are promised a very excellent evening's entertainment, and the names of the artistes are a guarantee that we will not be disappointed. The Soloists are—Miss Gladys Moger, Soprano; Mr. J. Stewart Wilson, Tenor; Mr. Clive Carey, Baritone. It is hoped that all lovers of music in the hospital will make an effort to be present. Tickets, price 2s. 6d. and 1s., may be obtained from the Hon. Secretaries, Messrs. H. Q. F. Thompson and J. J. Sterling Hill, or from the Matron's Office.

The Debating Society has had a chequered career during the last two years, and last winter it seemed likely that it must suspend operations for a little until some keen spirits should be found to revive it. However, we are glad to say that this pessimistic view has not prevailed and that, thanks to the energy of Mr. G. Neely, the honorary secretary, the Society has apparently entered upon a new lease of life.

The first meeting for this session was held on Thursday, November 27th, when a very fair number of men turned up, and, in addition, several very promising new speakers contributed to the discussion. The next meeting will be held on Thursday, December 11th, in the College, at 8 p.m. The subject for discussion is "That in the opinion of this House the Scotch, Irish, and Welsh element should be eliminated from this Hospital." There will, we are sure, be a very animated discussion upon so provocative a motion, and we admire the courage of the English section in thus boldly attacking the Celtic Fringe.

It is hoped that all old supporters of the society will rally to its support and help to establish it firmly once more, and particularly new men are urged to turn up and grace the society's meetings with their presence and, if possible, their views.

We publish this week an official notice from the Secretary of the Students' Club relative to that constant source of trouble, the catering in the College. The trouble has been brewing for a long time now, and there has been much hot-headed talk and strong language used in the matter. Personally, we think that the trouble depends chiefly upon two factors—firstly, that the caterer attempts a too ambitious bill of fare, and fails, for financial reasons, to carry it out satisfactorily; and secondly, that most men living in the College—and these are naturally the chief complainants—are not in general "fit," and, as we all know, one of the first and chief symptoms of poor health is capriciousness and loss of appetite.

Another subject which was discussed at the last General Meeting of the Students' Club was the question of the Telephone in the College. There has always been much resentment felt that the telephone on the ground at Honor Oak Park can be used on payment of a penny, whilst it costs twopence to make a call from the College. This point of view is one with which we have every sympathy, and we were glad to hear that the Students' Club are again going to approach the Clubs' Union Council in the matter. The question is, of course, finally a financial one, and the decision rests, therefore, with the Council. We hope that the Council will see their way at last to removing this anomaly.

Change of Address.

Dr. John Eyre, 57a, Wimpole Street, W. Telephones: Mayfair 5053; Brixton 1101.

Hedley C. Visick, L.D.S., from 39, Brook Street, Grosvenor Square, W., to 29, Queen Anne Street, Cavendish Square, W.

Charles E. Price, from "The Croft," Orpington, Kent, to Whyteleafe, Orpington, Kent.

The Pathology of Diabetes.

By J. H. RYFFEL, B.C.

Read before the Physical Society, November 19th, 1913.

In opening a discussion at the International Congress of Medicine, Dr. Garrod said that the ideal way to study disease would be to work out thoroughly the physiology of the processes involved, then to deal with the pathology, and finally to use the knowledge so obtained as a basis for treatment. To follow this ideal is obviously impossible, and would entail a considerable loss even to physiology, as many advances in physiology have taken their origin from pathological discoveries, yet it is necessary to remember that this is the logical order of enquiry, and that, where the physiology is not completely worked out, pathological views are essentially temporary. Particularly is this the case in a metabolic disturbance such as diabetes. Current views as to the metabolism of carbohydrate have undergone some alteration in recent years, so that it should be of interest to examine the pathology of diabetes from the standpoint of these changes.

Complete removal of the pancreas in animals causes hyperglycæmia and glycosuria, even when the animals are starved or are fed on materials nearly free from carbohydrate. Sandmeyer showed that glycosuria did not occur in dogs until four-fifths of the pancreas had been removed, and even then the glycosuria was of a mild order, dependent on the presence of plenty of carbohydrate in the food. Transplanted pancreas largely prevents the glycosuria as long as the transplanted tissue remains functional. Clearly then the pancreas exerts some chemical influence which prevents glycosuria, but attempts to obtain from the pancreas an extract which has this function have been almost entirely unsuccessful.

The most obvious explanation of the action of the pancreas is that it supplies an internal secretion which is of the nature of an amboceptor, and is necessary to enable the tissues to deal with sugar. In support of this view we have Cohnheim's well-known experiment, in which muscle juice and pancreatic extract together caused glycolysis, while neither liquid alone had this action. This experiment has, however, been repeated several times with mainly negative results, or with results which the authors attributed to the presence of bacteria. Last year Knowlton and Starling published experiments of a different kind which gave apparently convincing results. They employed a preparation of the heart and lungs of the dog, in which the animal's own blood was kept circulating by the heart's action, the lungs being ventilated with air, and determined the rate of disappearance of dextrose which was added to the blood both in the normal and when the whole preparation was obtained from the depancreatised dog. In the latter case the rate of disappearance of sugar was much

less than in the former, but rose to normal on the addition to the blood of boiled pancreatic extract. These experiments appeared to be sufficiently convincing and were partly confirmed by Maclean and Smedley using a perfused heart, but in October of this year Patterson and Starling published further results obtained with the heart-lung preparation, in which the difference between the rates of disappearance of dextrose in the two cases was not at all clear. Moreover, the depancreatised dog's heart was found to be richer in glycogen than the normal. Taking this into account they showed that, on increasing the heart's action by the use of adrenalin, the consumption of dextrose and glycogen together in the depancreatised dog's heart became very considerable and was not noticeably different from that in the normal under similar conditions. The apparent influence of pancreatic extract was due to its stimulant effect on the heart. It is remarkable that in pancreatic diabetes the glycogen of the heart should be above normal, whereas that of the liver and muscles is markedly diminished, so that the heart might differ from the other tissues also in its power of metabolising sugar, but according to Macleod and Pearce and also to Patterson and Starling the rate of disappearance of sugar from the general circulation after evisceration and ligation of the blood supply of the liver and kidneys is as great in the depancreatised animal as in the normal. The probable conclusion from this conflicting evidence is that the tissues of the depancreatised animal can metabolise dextrose as well or nearly as well as the normal. Have other considerations any bearing on this conclusion?

The severe diabetic, whether experimental or human, has a low respiratory quotient (0·7 or even less). This is generally taken as showing that carbohydrate is not metabolised, but the respiratory quotient is the resultant of all the processes taking place in the body at the time, and the diabetic is acknowledged to be making sugar from protein and fat—a process which produces an exceedingly low quotient, probably 0·3 or less—so that if the oxidation of carbohydrate were normal, the quotients observed could be accounted for by the formation and excretion of sufficient sugar formed from protein and fat. The low quotients observed mean, therefore, either that carbohydrate cannot be metabolised, or that the formation of carbohydrate is so great as to mask the oxidation of carbohydrate.

Again, the quotient of the severe diabetic is not raised by giving carbohydrate. The sugar in the blood is slightly increased, and the sugar in the urine increased according to the amount of carbohydrate given. This observation, also, does not prove anything to the point except that, when the sugar in the blood is already high, a slight increase thereof does not appreciably increase carbohydrate oxidation.

On the other hand, the respiratory exchange of the diabetic is normal except as to the quotient and its oxidative power is normal. Benzene can be oxidised to phenol, citric acid, glycuronic acid, etc., can be oxidised and used as a source of energy. When the substance is such as glycerine and lactic acid, which can be easily converted to dextrose, it serves rather as a source of dextrose than as a source of energy, with the result that the output of dextrose is increased.

The phenomena of diabetes can thus be as well explained by an abnormal tendency to form dextrose as by an inability to utilise dextrose. It is, therefore, important to consider the factors that lead to the formation of dextrose.

Glycosuria occurs in animals as a result of anæsthesia and operation, lack of oxygen, administration of carbon dioxide, fear and rage, and in man it is known to occur occasionally from nervous excitement, and other psychical disturbances. Injections of adrenalin and of pituitary extract both cause glycosuria. The conditions governing the liberation of the active principle of the pituitary are but little known, but those governing the liberation of adrenalin in the suprarenal have been extensively studied by Elliott and von Aurep among others. The activity of this gland is regulated by its nerve supply, and the quickening of the heart and rise of blood pressure that take place on stimulation of the splanchnics, stimulation of afferent nerves, administration of carbon dioxide, injection of lactic acid, and in lack of oxygen have been shown in each case to be due in large part to this activity, so that the conditions which cause temporary glycosuria are the same as those which cause liberation of adrenalin, and presumably the adrenalin bears a part in the causation of the glycosuria, but it is impossible to say at present to what extent activity of the pituitary and direct nervous action on the liver are also involved in this matter. As injection of acid causes liberation of adrenalin, presumably hard exercise, which causes the blood to become more acid, also has this effect. The blood pressure and pulse rate are markedly increased but glycosuria does not occur, as there is an increased consumption of sugar in the muscles.

When the suprarenals are excised, the sugar in the blood is diminished. This is also the case in Addison's disease, and as a result of injection of hydrazine, which causes necrosis of the suprarenals. Underhill and Fine removed the pancreas in dogs and then injected hydrazine. By this means they prevented the usual hyperglycæmia and glycosuria of depancreatisation. They point out the antagonism which exists between the suprarenals and the pancreas, the suprarenals causing the liberation of sugar and so increasing the sugar in the blood, the pancreas tending to diminish the sugar in the blood.

The depancreatised animal usually has acetonuria, though to a variable extent. As shown in Embden's experiments on the perfused surviving liver, the acetone bodies originate from the incomplete metabolism of fatty acids and of some of the constituent amino-acids of protein. Their occurrence in the intact animal is generally supposed to indicate lack of carbohydrate or nability to utilise carbohydrate, because they appear in

man's urine in starvation, and when his diet is nearly free from carbohydrate, and it is supposed that under these circumstances the metabolism of fatty acids is abnormal because of the absence of carbohydrate. The assumption, however, that an animal which is receiving no carbohydrate has no carbohydrate metabolism, is not justified by the facts. Pflüger's dog after starving twenty-eight days had 4·8 per cent. glycogen in his liver. The sugar in the blood of a starving animal is no less than that in the blood of the same animal when it is well fed with plenty of carbohydrate. These facts must surely mean that animals can make carbohydrate when required, so that Pflüger's view, that the acetone bodies result from the manufacture of carbohydrate from protein and fat, is the more tenable. On this view the occurrence of the acetone bodies in the blood and urine of diabetics means, not they cannot utilise carbohydrate, but that they are making it.

It is generally accepted that adrenalin and pituitary produce hyperglycæmia by causing the conversion of glycogen to sugar in the liver, and no one seems to have thought to enquire whether their excessive use cannot set the sugar-making machinery going and so cause acetonuria, so that there are no accurate data on this question. One or two facts are, however, suggestive: In the later stages of a twenty-four hours' walking race most of the competitors had acetonuria in spite of taking considerable quantities of carbohydrate. I once subjected myself to progressive lack of oxygen for over an hour finishing with 7·8 per cent. of oxygen in the chamber and a pulse of 120 per minute. The urine for some hours afterwards contained acetone bodies but no sugar, although meals were taken at nearly their proper times. The lack of oxygen should have been sufficient to excite secretion of adrenalin, and possibly this was the cause of the acetonuria.

Formation of carbohydrate from fat and protein, and liberation of acetone bodies would thus appear to be a possible result of activity of the factors which cause the liberation of sugar.

To sum up, there is no indirect evidence that the tissues of the depancreatised animal cannot utilise carbohydrate provided we accept Pflüger's explanation of the occurrence of acetonuria. The pancreas undoubtedly antagonises the accumulation of dextrose in the blood. In the present state of our knowledge we must suppose that the pancreas acts either by inhibiting the production of sugar or by assisting its transformation to glycogen, not by aiding its utilisation in the tissues.

As to human diabetes I shall limit my remarks to typical diabetes, that is to a condition which occurs from youth to middle age and is on the whole progressive until the patient dies in diabetic coma. In this disease the general phenomena are exactly similar to those shewn by the depancreatised dog, so that I need not recapitulate them here. There is one difference—the greater tendency to acidosis, but this is simply accounted for by the greater tendency to the liberation of the acetone bodies which exists in man. Clearly the balance of the factors, which regulate the production and destruction of dextrose in the body, is deviated in the direction of over-production of dextrose, but the components of this deviation are not necessarily the same as those in the depancreatised dog. The possibilities are:—

(i.) That the factors causing the liberation of sugar are excessively active. That this should be the primary disturbance seems very unlikely.

(ii.) That there is a great lack of active pancreas analogous to almost complete removal of pancreas in the dog. Against this possibility we have the evidence of morbid anatomy, that in the great majority of cases the pancreas is not very abnormal either macroscopically or microscopically. On the average the pancreas is smaller than normal and does not appear to be fully functionative, so that we can only say that there appears to be some lack of pancreas which may be a contributory factor.

(iii.) That the tissues cannot metabolise dextrose. Of this there is no proof. Further, it is unlikely that there is any great difficulty in this direction as, although diabetics are easily tired, the heart, kidneys and respiratory muscles are capable of a large amount of work.

(iv.) That there is some disability not necessarily very serious in itself, to which there is a reaction by activating the machinery of sugar production.

The last view, which is really a combination of the others, appears to be the only one tenable. As the sugar production is already in excess, those phenomena which tend to increase it should exaggerate the disturbance of equilibrium. These phenomena are excitement, hard muscular exercise, anæsthesia and acidosis.

Excitement increases both the sugar and the acetone bodies. Sleep produces the opposite effect, at any rate as to the sugar.

Although gentle exercise is said to be beneficial, hard exercise and excessive fatigue are harmful, increasing the acetone bodies.

The danger of anæsthesia is well known. As food is largely withheld, the sugar does not show marked increase, but the production of acetone bodies is greatly increased.

Where there is some acidosis the excretion of both sugar and acetone bodies can be diminished by a course of treatment with alkali. High grade acidosis is best considered in connection with coma.

Diabetic coma is, as far as we know, the terminal condition of all severe human diabetics. The characteristic feature is the enormous increase in pulmonary ventilation. This is not due to increased metabolism, the alveolar carbon dioxide being very low, even only 1 per cent., and the output of carbon dioxide not much greater than normal. On the modern theory of

the regulation of respiration these facts point to the blood being more acid than normal. That this is the case has been shown by Michaelis and Davidoff, who found that the concentration of hydrogen ions in the blood is definitely increased in spite of the low carbonic acid. The principal acids causing the acidity are diacetic and oxybutyric acids, which are present in large amounts in the blood. Kennaway's average result obtained post-mortem was 0·266 grm. per 100 c.c. for both acids together expressed as diacetic acid. Taking 50 litres as the volume of liquid in the body, this represents 133 grm. in the body, equivalent to roughly 100 grm. of sodium bicarbonate. The difficulty in neutralising these acids by means of intravenous injections is sufficiently obvious.

The onset of coma is characteristic. For some time previously the urine has contained considerable quantities of the acetone acids and the output of ammonia has been definitely above normal, but the body has remained capable of neutralising its acids, and there is no actual acidæmia, as shown by the alveolar carbon dioxide remaining within normal limits. Then, usually from some disturbing cause such as change of diet or surroundings, the acid production becomes too great and acidæmia results as shown by a fall in the alveolar carbon dioxide. Unless the acidæmia is successfully treated by means of alkalies, the diminution of carbon dioxide is progressive, the rate of diminution being at first slow and then finally rapid until typical coma is established. Clearly the process works in a vicious circle, acidosis begetting acidosis. This would be explained if the main factors in causing the acidosis were the sugar-producing internal secretions whose production is excited by acidæmia. It is rarely possible to save the patient by means of alkalies when the coma has become fully established. This, again, we should expect, as it would be necessary to bring the blood and tissues actually to normal reaction before the excessive secretion could be stopped.

As far as they go, these considerations point to excessive production of sugar in diabetes, though what is the actual exciting cause we cannot say.

I am very sensible that in this account there are many gaps left vacant and questions unanswered. All I desire is to lay stress on the production side of diabetes, which seems to have been neglected in recent years.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette." Guy's Hospital, London, S.E.*

Guy's Hospital Dental Society.

The Second Meeting of the above Society was held in Class Room No. 2, on Friday, November 21st, and there was a fairly good attendance. There seems to be some misunderstanding about the time of these meetings. They are supposed to start at 4.15 p.m., and tea is at 4 p.m., not at 4.15 p m. as some members evidently think.

Casual communications were presented by Messrs, Barnes, Bradley, and Clewer.

Mr. Clewer then read his paper entitled "The Dental Aspects of Trigeminal Neuralgia." It is not necessary to say much about it here as it will be found in another part of this issue, but it certainly showed that Mr. Clewer had taken great pains to write as comprehensive a paper as possible.

Mr. Aubrey opened the discussion by stating that we must not look upon neuralgia as a disease, but rather as a symptom, probably always of organic disease. The pain is always very great and relief can only be obtained permanently by the drastic operation of removing the Gasserian Ganglion. He stated that extirpation of the ganglion often adversely affected the eyes and mentioned that sometimes the ophthalmic division of the sixth nerve was left to mitigate this evil. Injection of the ganglion with alcohol was a very dangerous proceeding, and did not effect permanent results, as the injection had to be done annually. He said he was glad that Mr. Clewer had not laid stress on "oral sepsis" as the cause of neuralgia, because nowadays "oral sepsis" was put down as the cause of almost everything without much evidence in its support. He emphasized the fact that one must look carefully round the mouth in dealing with a patient suffering from neuralgia as the pain was practically always referred.

The discussion was continued by Messrs. Saul, Lowein, Neely, Laver, Barnes, Welton, and Whitten.

Mr. Lowein seems to have gained a vast personal experience in the short time he has been in the Conservation Room, and he treated us to one or two personal reminiscences.

Mr. Laver's contribution is worthy of notice; he evidently thought the discussion was a trifle too technical so he proceeded to broaden our outlook by broadening the basis of the discussion.

A vote of thanks was then passed to Mr. Aubrey for taking the chair in the unavoidable absence of the President. The meeting ended at 5.38 p.m.

The next meeting will be on Friday, December 12th, when Mr. Underwood will read a paper on "Bands."

DENTAL CORRESPONDENT.

The Resurrectionists.

IX.

"Consider—ere as furious as a griffin
Against a glass of grog you make such work,
A man may like a stiff 'un,
And yet not be a Burke!"
Ode to Admiral Lord Gambier, HOOD.

THE story of the Resurrectionists would be told were it not that the more comprehensive term *body-snatching* includes adventures other than those associated with exhumation.

From time to time, but more particularly in the later years of the traffic when graves gave up their dead less easily, the body-snatcher sought to obtain his prey by other methods.

Certain of these ruffians were not slow to discover, when exhumation had become increasingly difficult, that there were other means of attaining the same object which were far less laborious and involved considerably less risk. It was found, for instance, that the lowest class of undertaker, then in the habit of retaining bodies for some days before burial, could be persuaded to part with them upon terms that still offered a reasonable profit to the resurrectionist. For the undertaker himself never dared to approach the surgeons for such a purpose and was, consequently, content to accept a smaller price than would have been demanded had he been a free agent. It would be useless to guess how frequently the burial service was read over a coffin-load of brickbats by unsuspecting clergymen at this period. Outrages of this nature were especially common about the years 1825 and 1826; and the practice only ceased when the quarrels among the resurrectionists made it too notorious to be continued.

The absence of any signs of burial aroused no suspicions in the mind of the anatomist, for the condition of the bodies received from different sources varied between wide extremes. To borrow a phrase from the reminiscences of Albert Smith's "Dissecting-room Porter," the bodies from Old Bailey were "fresh and sound," whereas "the stiff 'uns from the resurrection men were sometimes all shades of tint, like a soaked harlequin whose colours had run, and would hardly bear injecting." The body of Southey's "Surgeon" was discernible "full four yards off," but for another reason; and there are passages in Naples' diary that seem to imply that even after a cadaver had begun to putrefy it was possible to dispose of the extremities if these were still unaffected.

The anatomist had no cause for alarm if by chance a recent subject came his way, and this knowledge emboldened the resurrectionist to pursue methods which, although at first comparatively innocuous, eventually led to his undoing.

From acting as the intermediary of a rascally undertaker it was a short step to more audacious methods. At all times in a great city numbers of nameless dead claim the attention of a coroner and his jury, and these bodies frequently passed into the hands of the resurrectionist either before or after an inquest. "Patrick," once, on learning that a woman had been found drowned in a canal near Sydenham and was then lying in the stable of a public-house, ascertained by discreet inquiry that the body was probably that of a pauper from Woolwich workhouse and, therefore, unlikely to be claimed for burial by relations. He learned, too, that the watchman appointed by the parish authorities, considering himself insufficiently paid for his task, had determined to keep no watch that night. Later in the same evening Patrick returned with a companion, picked the lock of the outhouse, and carried off his prize to London. Next afternoon, in the "Elephant and Castle," Patrick was informed by a coachman of his acquaintance of a singular occurrence at Sydenham, where a coroner's jury had met to hold an inquest on a body that had mysteriously disappeared.

By a similar theft Guy's Hospital was once placed in a false position, and subsequently "returned to Vestry Clerk of Newington one male and two females, purchased of Page . . . who had broken open the deadhouse to obtain them."

Another device was that of claiming, in the character of a relation, bodies of friendless paupers who had died in the workhouses or infirmaries. Here they were sometimes aided by the indifference of the parish officials who, considering that such a removal would relieve the parish of the burial expenses, did not trouble themselves overmuch in investigating a dubious claim.

This practice, likewise, was the invention of Patrick, and by this means he secured a considerable number of bodies from St. Giles's and other workhouses. The method demanded variety in his assistants, for his wife, whom at first he employed to claim these friendless bodies, at length became too well known, despite her numerous disguises, to continue the deception in safety. Another representative was called in to assist her, a sturdy rogue named Couchman who was to play the part of the undertaker's assistant who removed the subject in a plain shell towards nightfall.

As so often happened, Patrick's success aroused the envy of Murphy, who applied himself to discover his rival's methods. He waylaid Couchman, whom he knew to be concerned in the enterprise, and after plying him with a hearty meal accompanied and followed by much rum-and-water, proposed a future partnership, stipulating at the same time that there should be no secrets between them in regard to manœuvres of the past. Having thus gained the information he desired, Murphy easily persuaded Couch-

man that he would be handsomely rewarded for betraying Patrick's secrets to the Board of St. Giles. Couchman, in a somewhat confused state, was dispatched in a hackney-coach to the workhouse, and there revealed to the master not only the past transactions, but the intention of Patrick's wife to take away a body on the following day.

When Mrs. Patrick next presented herself at the workhouse she was confronted with a group of genuine relations and carried before a police magistrate. Later in the day she and her husband were arrested and committed for trial on a charge of "owning and obtaining bodies under false pretences." Eventually, however, they were both discharged, although both Couchman and his wife had fully incriminated themselves in giving evidence against them. Part of Mrs. Couchman's testimony was a minute description of the dress provided for her, including a clean white handkerchief with "directions for use"!

Supervision after this became much more strict, but the body-snatchers were still by no means at the end of their resources. Some of them would appear to have cultivated an almost vulturine prescience of death. A professional resurrectionist, who happened one day to be walking in the neighbourhood of one of the great London hospitals, saw a man stagger and fall heavily to the ground. Running to his assistance, he quickly perceived that the stranger was already dead, and with an immediate change of plans, set himself to bewail the death of "his cousin" and to implore the assistance of passers-by in conveying his kinsman to the hospital, whilst audibly expressing his fear that it was too late. Next day the body, after forming the subject of an inquest, was handed over to the care of the resurrectionist, who quickly disposed of it at the school of another hospital.

On the numerous occasions when these rogues fell out among themselves, one form of revenge lay in informing the police that a subject, already sold to a school of anatomy, had been procured by a rival in unlawful fashion. Such information resulted in the issue of a search-warrant and the seizure of the body at the expense of the unhappy anatomist. Not only had the aggrieved body-snatcher the satisfaction of seeing his rival harassed by the police, but, by good luck, it was sometimes possible for an accomplice, posing as a relation, to secure the body from the authorities and sell it elsewhere.

Still more outrageous were thefts from the house of mourning itself. A man-servant employed in a large house not far from London paid a visit to his friend "Patrick" to inform him that his master had just died, and that, as the body was lying in a back parlour overlooking the lawn, a good turn of business might be possible. The funeral had been arranged for the following Sunday, and Patrick thereupon concluded that the screwing down of the coffin would take place not later than Saturday. Reassured on this point, he arrived at the house on Saturday night and was admitted from the lawn by the servant. In complete darkness the coffin lid was unscrewed, the corpse replaced by a quantity of loose earth from the garden of approximately the same weight. The coffin was again screwed down and restored to its former state beneath the pall, while the body, concealed in a box, was taken away and hidden in a tool-shed at a distance from the house. On the Monday morning the box and its contents were transported to a private school of anatomy and sold for fifteen guineas. But Patrick, in the meantime, had attended the funeral, and to make sure that the ceremony was proceeding in due order had sat through a sermon of over an hour's duration.

A Jew named Israel Chapman, living in Field Lane, was another who obtained many bodies in a like fashion. Generally he stole them from the poorer tenement-houses of his own neighbourhood; but he finally came to grief by stealing a body from a more important dwelling, and was captured by a police-officer who had been stimulated by the offer of a large reward.

Other tales that are told reveal a callous brutality in the resurrectionists that is almost past belief. It is said that a body-snatcher hearing the passing bell would seek out the house where relations were watching over a dead child, and, after some pretence at sympathy, would fetch from the nearest public-house some fluid comfort to support the mourners. As soon as they were under the influence of the drug he had placed within it, he seized the body and escaped.

In the poorer Irish quarters the ceremony of "waking" a deceased friend sometimes afforded an opportunity to a band of resurrectionists to rush into the room, seize the corpse and decamp almost before the mourners had had time to realise their loss. Now and again, however, the pursuit was close upon their heels, and the resurrectionists escaped trailing a naked corpse in the mud, the mourners in full cry behind them.

How frequent these thefts became may be guessed from the statement that one London police officer alone was able to recover between fifty and a hundred of the bodies thus stolen.

To such a pass had matters come before any decisive action was taken to make an end of this hideous business. Timid palliative remedies had been attempted with a view to rendering the anatomist independent of the ministrations of the resurrection-man, but without success. For a while cadavers were imported from the Continent, where the opposition to the pursuit of dissection had never arisen to anything approaching the degree of prejudice that prevailed in England. But this source of relief was soon brought to an end by the high-handed action of the Customs' officials who either exacted prohibitive and arbitrary fees under the disguise of an *ad valorem* duty or refused to forward the bodies at all and insisted on their immediate burial. Finally, when the importation was

duly authorised by the Secretary of State, it frequently happened that their condition was such that they were useless for dissection.

It was very evident that such a state of affairs could not be permitted to continue indefinitely. Members of the profession were by this time quite certain that medical education would be futile without dissecting; but, on the other hand, statesmen had long considered it "too hazardous a risk to attempt the enactment of laws on the subject, for the necessary publicity of the discussion upon them, it was feared, would render such a proceeding liable to defeat the very object for which it was instituted," and so it was the blind eye that remained directed towards the resurrectionsts' trade, since, after the national habit, statesmen and politicians ordained that a crying evil must be endured if it might not be openly discussed.

At length the profession obtained a hearing, and in April, 1828, the subject was raised in the House of Commons. Mr. Warburton there stated that whereas in the previous year eleven bodies alone were legally disposed of, eleven hundred had been required, and nine hundred actually obtained. A committee to inquire into the whole question was at once appointed and commenced its sittings before the end of the month.

In the same year a committee of the Royal College of Surgeons in Edinburgh furnished the results of an "Enquiry into the state and opportunities of education with regard to Practical Anatomy in that city."

But in that same city, in October of the same year, there was an even greater force working upon the solution of the same problem. Although it had been deemed expedient to shield the ear of the public from the distasteful truth regarding the body-snatcher's trade, these precautions were rendered needless in 1829 and the years that followed by the sinister intervention of Burke and Hare and others of their kind.

(To be concluded.) R. M. W.

A Case of Pneumococcal Infection in a Baby.

By Dr. H. O. BROOKHOUSE AND Dr. H. C. MANN.

WE think that this case of severe illness resulting from pneumococcal infection with primary trouble in the lungs, successfully treated as it was by vaccine, may well be recorded in the GAZETTE.

Vaccine Therapy, we are told, is still upon trial. Indeed, there are some who would have us believe that, as a form of treatment, it is already obsolescent, and that like the latest synthetic remedy, it will be unknown and discredited with the coming generation. The tendency, perhaps, at the present time is to dwell too much upon those cases where a vaccine has failed, rather than to remember the numbers of cases in which drug treatment, even upon the most approved lines, has failed to produce any effect whatever. This is our apologia for reporting what is apparently a striking success.

In the first place, at such an early age, the pneumococcus is more often a cause of dangerous illness than any other organism, and, as everybody knows, too often there is a fatal termination even when the child has seemed to be of robust constitution up to the onset of trouble and when every detail connected with home and mothercraft is irreproachable. In this particular instance we were happy in having good nurses, and in knowing that if anything should be wanted it could be procured immediately.

Secondly, the use of a pneumococcus vaccine entirely changed the whole aspect of the case. No one can say that we immediately rushed to employ that form of treatment without considering the pros. and cons. The position was that after eighteen days of continuous pyrexia maintained, apart from sponging, between 101° and 104·6° F., we were faced with the fact that the baby was becoming progressively more poisoned by the infection, was refusing feeds, and in addition, after that time had elapsed, a considerable amount of albumin had appeared in the urine. The outlook was horrid. On the nineteenth day of illness the vaccine was given and thirteen hours after that injection the temperature had fallen to 99° F., for the first time, apart from sponging, since the fever started. In nineteen hours the temperature was subnormal, and a favourable change in the general condition of the baby was unmistakable. Both o the other two injections of pneumococcal vaccine which were given seemed to produce a similar effect with the intermittent pyrexia which followed. A stock vaccine was employed.

The patient, W. A., was born on April 1st, 1913. He comes of a rather nervous, but otherwise healthy stock. He has one brother who is quite well, age 3½ years.

W. A. weighed 8 lbs. 13 ozs. at birth. He was never breast fed, but was brought up from his earliest days on the Clay-Paget Company's milk which seemed to suit him very well, though he lost a little weight during the first month. At the age of four weeks he weighed 8 lbs. 12 ozs., at eight weeks 11 lbs. 3 ozs., at twelve weeks 13 lbs. 7 ozs., and at twenty weeks he was 15 lbs.

On August 28th he first seemed unwell, he became feverish, vomited after several of his feeds, and the motions were loose, not profuse, but streaked with bile and rather offensive. Up to this time he had taken four ounce feeds of Clay-Paget milk about every 2½ hours without trouble. Next day, August 29th, he was fretful and feverish, he would only take a three ounce feed very slowly, and there was a little difficulty in giving it. On August 30th it was thought that he was "slightly convulsed." August 31st, his weight had fallen to 11 lbs. 8 ozs. In the morning there was a minor convulsive seizure, he became rigid and slightly cyanosed. There was another slight attack in the afternoon. His temperature was 102° F. September 1st, feeds were taken slowly, and he was feverish. In the evening, 9.30 p.m.,

the eyes and face were noticed to be twitching, he vomited a feed of milk, and later some bovinine.

September 2nd, he was drowsy, the temperature in the morning was 103°, and he had passed a restless night. His mother, who possessed far more than the usual lay knowledge of matters medical, was quite sure that meningitis was developing, and on this account we saw the child, together, in the afternoon. At that time he was still inclined to be drowsy, never really stuporose. There was no photophobia, the pupils were equal and reacted equally to light. Though some slight rigidity of the limbs and cervical muscles had been present upon the previous day, these symptoms had passed off, and the child did not in any way resent examination. At the same time he was a nervous baby, who started at any sudden sound, even a slight one, and for this reason we could not help wondering if we were paying too much attention to the temperature as a possible sign of trouble. The child gave single coughs at very infrequent intervals. There were no adventitious sounds to be heard in the lungs, and the vesicular murmur was a normal one throughout the chest. We noticed, however, that the respiratory rate was more rapid than might be expected from the pyrexia, and that in successive quarter minutes it was very variable—10, 8, 15, and 6 being counted. The rate per minute varied between 35 and 50. We were inclined to suspect that there was some pulmonary mischief, and we did not think that the child had meningitis. Because the vomit had been markedly acid, the stools loose, and with our knowledge of the prevalence of summer diarrhœa, we decided to give no purge, to omit the Clay-Paget milk, and to feed with a milk and water mixture of three parts to one, fully citrated and alkaline, using a feed of four ounces as maximum, and feeding at 2½ or 3 hourly intervals. The urine was found to be normal, and diminished excretion was not reported. During the next few days there was little change to record in the child's condition, the pyrexia persisted, so that we decided to employ sponging whenever the temperature reached 103° F.

The intermittent cough persisted—not troublesome, but it was definitely noticeable, and the respiratory rate remained unduly rapid. A prescription containing 3 minims of tincture of belladonna and 2 grains of potassium bromide with syrup of tolu, was ordered, and the medicine given four hourly. This certainly controlled the cough and no râles appeared. Occasionally there were sibilant rhonchi. The situation on September 10th was that the child seemed distinctly weaker. The temperature could be controlled by sponging, but apart from this, remained between 101° and 103° F. This can be seen by reference to the charts, where the lower row of single "dots" represents the temperature readings taken half-an-hour after sponging had been practised. On September 12th the child was much worse. The temperature on the whole was higher in spite of repeated sponging. The respiratory rate varied between 40 and 52 per minute. The entry of air was satisfactory; sibilant rhonchi were rather more numerous. No alteration in the quality of the vesicular murmur was detected. Feeds were given by spoon with great difficulty and the child was more stuporose; the lips had a faintly purple tint. Later in the day, under the spine of the right scapula, the entry was found to be deficient and the adventitious sounds were rather more numerous. Throughout the week the stools had been loose, pale in colour, occasionally streaked with bile, numbering three to five daily, and not in any way foul in odour. The urine also had remained normal. A small dose of urotropine had been given for some days with the idea of preventing infection of the urinary tract. Next day, September 13th, we again saw the child together and agreed that the condition was grave. There were no evidences of consolidation, but the signs of a "dry bronchitis" persisted, the baby was more cyanosed and stuporose, being roused for feeds only with difficulty, and these were taken very badly. We thought that the condition was a pneumococcal toxæmia and we decided to employ a stock vaccine which was prepared for us by Dr. John Eyre. A blood film was taken. This showed an obvious leucocytosis and a relative increase in the large mono-nuclears. A sterilised specimen of urine was also obtained. A considerable quantity of albumin was found, a trace of blood, and pus cells. Dr. Eyre reported a mixed growth of bacillus coli and pneumococci. This secondary infection of the urinary tract with the bacillus coli is, we understand from Dr. Eyre, of no rare occurrence in cases of pneumococcal infection, and acting on his advice we decided to try the effect of an autogenous bacillus coli vaccine as well. A fæcal smear was also found to contain gram positive diplococci. We also continued the administration of three grains of urotropine with five grains of sodium ortho-phosphate. The diluted feeds of citrated alkaline milk, which had been given with difficulty during the past fortnight, were changed to three ounce feeds of whole citrated milk, and as these were taken well the feed was subsequently increased to a bulk of four ounces. In addition a drachm and a half of malt extract per diem was ordered. The first injection of pneumococcus vaccine, 500,000, was given at 1 p.m. on September 15th (*i.e.*, the nineteenth day of illness). The effect of this injection has already been mentioned, and the fall in temperature can be studied on the charts which are appended. The improvement in the general condition of the baby in the course of twenty-four hours was very marked and quite remarkable. On September 17th a trial injection of 250,000 B. coli vaccine wa given at 11.15 a.m. This was not repeated as the urine rapidly cleared of albumin and pus, and on September 23rd there was only a faint trace. The second dose of pneumococcus vaccine, 500,000, was given on September 20th, and the last injection of 700,000 was given on the 27th.

From September 25th to October 1st the respiratory rate remained unduly rapid, with a coarse vesicular murmur. Occasionally fine râles were heard. No impairment of the percussion note was ever detected.

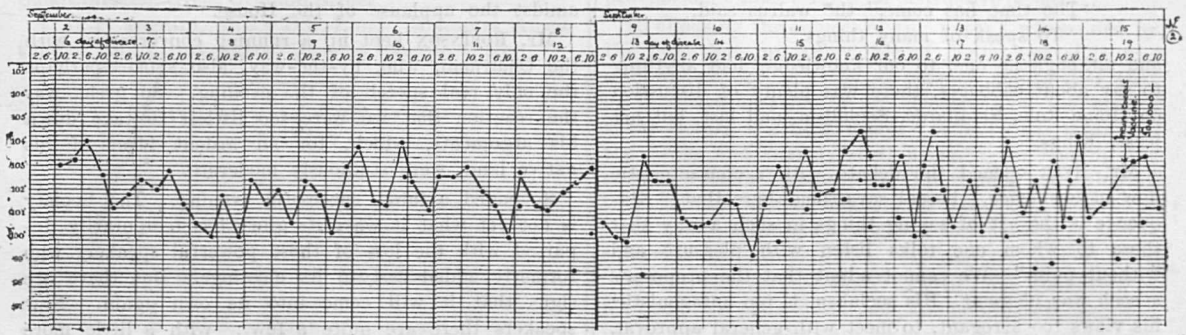
An uninterrupted recovery followed, apart from the appearance of a small abscess in the ischio-rectal fossa which discharged a greenish-yellow pus. This was opened and scraped and healed up in a week.

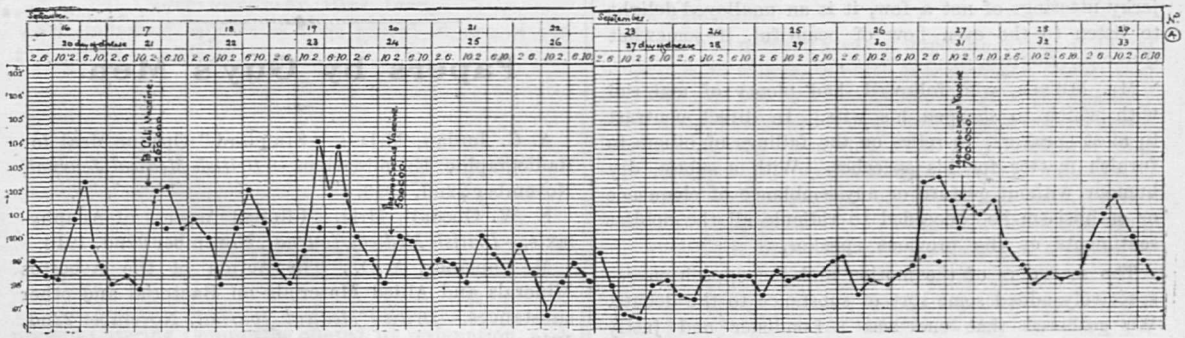
A first tooth erupted on September 27th, and a second tooth on October 19th. The subsequent weighings were as follows:—October 12th, 13 lbs. 8 ozs.; October 19th, 13 lbs. 9 ozs.; October 26th, 14 lbs.; and November 2nd. 14 lbs. 9 ozs. Throughout October the chest has been quite clear. The child is now apparently quite well; he is taking daily five seven-ounce feeds of undiluted citrated milk.

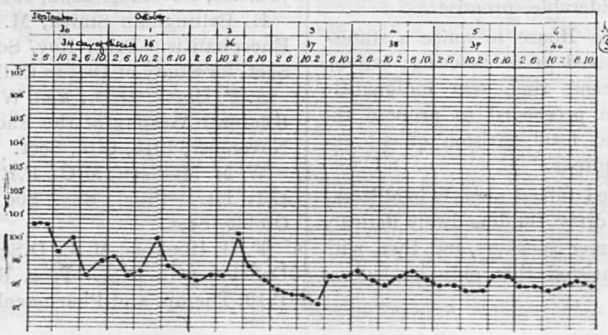
We want to acknowledge our indebtedness to Dr. Eyre. He didn't only prepare the vaccines. We had the advantage of his knowledge of pneumococcal infections, a knowledge which is very great and universally recognised.

The temperature charts are appended.

The lower row of single "dots" represent readings that were charted after sponging the baby.







Guy's Hospital Debating Society.

A MEETING of the Debating Society was held in the Smoking Room on Thursday, November 27th, at 8 p.m. Some 35 men turned up to decide whether Sir Edward Carson should be impeached or no, and although most of them voted on the division, only a dozen or more had anything to say. As usual, members had no idea of keeping to the point.

"The time has come," the walrus said,
"To speak of many things,"

and although no one, to our knowledge, had anything to say about cabbages, there was plenty of discussion on Home Rule, Spaniards, Socialism, and last, but not least, Kings.

MR. RYLE opened the debate with a characteristic flow of eloquence. Pascal says somewhere that "Eloquence is the art of saying things in such a way that those to whom one talks listen with pleasure and without pain." We cannot admit that the proposer's speech was pleasant. His socialism is too antagonistic, his views too arrogant, to meet with general approval. Yet, in so far as his delivery is dramatic, incisive, and clear, his speeches are certainly eloquent, in the strict Pascal sense, for amid the mumblings of many, the jerky utterings of not a few, it is an unalloyed delight to listen to the even flow of beautiful, if somewhat Quixotic, English.

MR. MILLER, who followed, had plenty of material with which to sharpen his wits. In direct contrast to most speakers, he relies on the failings of others to furnish matter for his speeches. With a subtle, dry humour, without gesture, or any semblance of eloquence or enthusiasm he proceeded to ridicule all the noblest sentiments of the previous speaker.

The seconders of the motion and the opposition respectively added some sort of substance to the debate. We gathered that one was a Londoner and justly proud of the fact, though unhappily he had been Scotch; that the other disliked Carson, and would have him impeached. Both men hail from the dissecting-room, and show considerable promise.

MR. SAMPSON treated the House to quite a statesmanlike outburst, and received great cheering; but on wishing to get up a second time was indignantly howled down; whereon he proceeded to propose the alteration, amendment, and total revision of all existing rules. "Renewed uproar."

An Irishman who followed talked sweetly in alliterative verse. He delved in dirty Dublin, dwelt daintily on the delinquences of former speakers, and then with a true Irishman's logic insisted that only he had as yet spoken to the point.

MR. MARSHALL had some pretty stories to tell of Carson, and left us all quite happy and unbiased.

MR. PEDLEY is too modest, with a style which is as unique as it is pleasing; he jerks out a few delightfully sonorous and jerky sentences, and then sits down just as one begins to realise his possibilities as a speaker.

MR. BEVAN BROWN, however, is of a different order. He didn't care tuppence—said it twice. "Be blowed to Carson," quoth he. As a free lance he was wholly entertaining.

The member from Costa Rica repudiated with vigour a reflection on his ancestral country, and sat down amidst the applause of the House.

MR. ROBINSON kept up a running conversation with the Chairman, who, by-the-way, also spoke—perhaps the only real speech of the evening. So great was the reaction that we were too listless to take down his arguments, which, for an ardent lover of his native land, were studiously moderate.

So ended a fairly successful evening. The Society is not yet what it was; its glory has temporarily departed with the loss of those powerful speakers who formerly added zest to its meetings. But there are signs that it will come into its own again. New speakers there are quite a few; with a little more confidence and experience many of them should rival the giants of debate who drew crowded Houses only a few years since.

Papers by Guy's Men.

A. C. Jordan, M.D.: "Standard" Opaque Meal for Radiographic Examinations.—*British Medical Journal*, November 22nd, 1913.

E. W. Goodall, M.D.: Clinical Aspects of Anaphylaxis.—*British Medical Journal*, November 22nd, 1913.

M. Coplands, M.D.: The Action of the Asbestos Minerals and Allied Materials on Bacterial and other substances.—*British Medical Journal*, November 22nd, 1913.

M. Coplands and Another: On the Action of Asbestos on certain Physiological substances.—*British Medical Journal*, November 22nd, 1913.

E. Bellingham Smith, M.D.: Case of (?) Cerebellar Encephalitis.—Proc. Roy. Soc. Med., November, 1913; Sect. for Study of Dis. in Child.

A. F. Hertz, M.D., and W. Johnson, M.D.: Case of Bilateral Atrophy of the Face.—Proc. Roy. Soc. Med., November, 1913, Clin. Sect.

W. M. Mollison, M.C., F.R.C.S.: A Case of Injury to Left Ear.—Proc. Roy. Soc. Med., November, 1913, Otolog. Sect.

F. G. Hopkins, M.B., D.Sc., F.R.S.: Diseases due to Deficiency in Diet.—Proc. Roy. Soc. Med., November, 1913, Therap. and Pharmacol. Sect.

Appointments.

Civil.

Lancelot Bromley, M.A., M.B., M.C. Cantab., F.R.C.S. Eng., Surgeon to Out-Patients, Victoria Hospital for Children.

H. L. Duke, M.D., B.C., has been appointed Bacteriologist to the Uganda Protectorate.

E. M. Mahon, M.B., B.S., House-Surgeon to the Female Lock Hospital, Harrow Road, W.

Sir W. Arbuthnot Lane, Bart., M.S., F.R.C.S., has been appointed Emeritus Surgeon at the Hospital for Sick Children, Great Ormond Street.

P. C. P. Ingram, M.B., B.S. Lond., Honorary Anæsthetist, Royal Government Hospital, Newport, Mon.

University of Cambridge.

Degree conferred.—M.D.: H. L. Duke.

Pass List.

University of London.

Third (M.B., B.S.,) Examination for Medical Degrees, October.

Erulkar, A. S. | Joly, J. M.

Shearwood, A. L.

Supplementary Pass List.

The following candidates have passed in one of the two groups of subjects:—

Group I.

Bennett, T. I.

Group II.

Evans, H. W. | Roberts, C. S. Lane.
Gould, C. H. | Webb, H.

Notices.

At a General Meeting of the Students' Club, the present Catering Committee offered its resignation, and a new Committee was appointed with the following terms of reference: "To meet fortnightly and discuss any written complaints which had been sent to it."

For this purpose a complaint box has been put up outside the College Reading Room. Any complaints as to the catering must be put in this box, duly signed and dated. No communication which does not bear the actual name of the complainant will be considered.

The Committee consists of the President of the Residents, Mr. G. S. B. Long, Mr. F. V. Bevan Brown, and Mr. E. D. Scott (Convener), and is instructed to report to the Annual General Meeting of the Students' Club in March next.

T. B. LAYTON,
Hon. Secretary.

Guy's Hospital Students' Club.

The Dental Aspects of Trigeminal Neuralgia.

Mr. Chairman and Gentlemen,—It is with the utmost diffidence that I bring this paper before you this evening. Not only do I fear that I am unable to do justice to such a problematical subject as neuralgia, but also I am confident that it cannot compare with the facetious wit and subtle banter of the paper which Mr. Neely read at our opening meeting. Be that as it may, it is my hope that these few remarks I am about to inflict on you will provide some material for an instructive debate.

In choosing the subject of this paper I was guided by the fact that my knowledge of dental neuralgia was somewhat conspicuous by its absence, and further, that on approaching some of my colleagues on the matter there seemed a general desire "to fold their tents like the Arabs and silently steal away." On reading the subject a little I became very interested, and thinking that perhaps others might also have somewhat hazy ideas about neuralgia, I was led to choose that as the subject of my paper.

It is, I believe, customary to give some defination of the condition under discussion, and neuralgia is described in the text-books as "pain occurring in the course of a nerve or within its area of distribution." When such pain is referred to a tooth or teeth it is known as "odontalgia," but when referred to other parts it is called neuralgia.

The cranial nerve of greatest importance to us as dental workers is, of course, the fifth or trigeminal. Repetition may tire you, but as a correct knowledge of the anatomy of the parts concerned is essential, I propose to recapitulate and jog your memories. You may remember that this all-important nerve emerges from the side of the pons varolii near its upper border, by two roots, a small motor, and a large sensory. The motor fibres arise from two nuclei, the upper nucleus consisting of a strand of cells in the grey matter of the sylvian aqueduct. The chief motor nucleus is, however, lower down on the side of the pons varolii, along the line of the lateral margin of the fourth ventricle. The sensory fibres come from the gasserian or semilunar ganglion, which is lodged in that depression of the dura mata at the apex of the petrous portion of the temporal bone which is known as the cavum meckelii. These sensory fibres have their nuclei in close relation to those of the motor root. Small communicating branches are received from the carotid plexus of the sympathetic. The gasserian ganglion divides into three great branches of distribution, the first or ophthalmic division, the second or superior maxillary, and the third or inferior maxillary. The first division goes through the sphenoidal fissure and supplies sensation to the cornea, iris, and ciliary muscle of the eye, the conjunctiva, lachrymal gland, and parts of the nasal mucous membrane, as well as the skin of the eyelids, eyebrows, nose, and forehead.

The second division leaves the skull by the foramen rotundum, crosses the spheno-maxillary fossa and enters the orbit by way of the spheno-maxillary fissure. Here it traverses the infra-orbital canal and appears on the face by the infra-orbital foramen. It supplies branches to the orbit, nose, lips, palate, and all the upper teeth.

The third division is a very important one. It is the largest of the three divisions and has two roots, a sensory and a motor, which unite outside the skull after their exit through the foramen ovale. Thus, the third division of the fifth partakes of the nature of a spinal nerve.

The distribution of the branch is extensive and important. It supplies sensation to the mandibular teeth and gums, the integument of the temple and ear, and the lower part of the face and lips, a large part of the tongue, as well as motor supply to the muscles of mastication.

Having enumerated the branches and distribution of the fifth nerve, I would ask you to consider the bony canals traversed by certain branches, as these points are of special importance. Here the inflamed and irritated nerve is unable to swell without being subjected to severe pressure and consequent pain. All three divisions traverse bony canals and emerge through foramina on to the face. The first division emerges through the supra-orbital foramen or notch, the second through the infra-orbital, and the third through the mental foramen. The surface markings by which these spots may be found are as follows:—

The supra-orbital foramen is situate at the junction of the middle and inner thirds of the supra-orbital arch. If a line be drawn from this point to the lower border of the mandible so that it passes between the lower premolar teeth it will pass over both the infra-orbital and mental foramina. The former being situate 1 C.M. below the margin of the orbit whilst the latter varies with age. In the adult it is midway between the upper and lower border of the mandible; in the child it is nearer the lower border, and in edentulous old age it is close to the upper margin.

Bearing these points in mind one can more easily grasp the significance of what are known as the "segmental areas of hyperæsthesia," that is to say, areas of increased sensitiveness to which I shall refer in detail later.

Neuralgias of the 5th nerve are of two main types, the most serious being known as neuralgia major, or to be precise, neuralgia quinti major, and the second and more common as neuralgia quinti minor. The major type is the rarer and more serious of the two conditions, but the treatment is not usually in the hands of the dental surgeon. I will not, therefore, dilate on the condition, nevertheless, as the dentist frequently has the first opportunity of recognizing the malady, it will be well to describe the symptoms and briefly indicate the treatment which is adopted in these cases. Neuralgia major generally makes its appearance between the ages of 35 and 60, more frequently in women. The patient is suddenly attacked by pain within the peripheral course of one of the branches of the trigeminal nerve; this lasts for some hours or even days. Probably a dentist is consulted and a diseased tooth or teeth extracted or treated. This may give temporary relief, but soon the pain returns and gradually increases in frequency and severity.

Predisposing factors are such mental conditions as shock, business worries, and the like, such untoward conditions as constipation, nasal catarrh, sudden changes of temperature, and even the normal act of deglutition. Pain paroxysmal in character generally starts from one definite focus although it may afterwards be referred over the whole area of distribution of the fifth nerve. The foci at which an attack may start are any one of the following:—The infra-orbital foramen, the mental foramen, the inner canthus of the eye, a spot over the posterior part of the zygomatic arch, and the lateral margin of the tongue. The pain is so severe as to be likened to a red hot wire being plunged into the flesh. It is generally unilateral and is accompanied by a hyperæmia of the conjunctiva with photophobia or inability of the eye to tolerate light and consequent lachrymation, flushing of the face on the afflicted side, trophic changes resulting in alteration of colour or even loss of the hair and beard over the painful area, and hyper-secretion of saliva. The pain is so intense and such large quantities of hypnotics have to be given in the later stages that the patient may become insane and, in fact, every patient with major neuralgia of advanced duration should be looked upon as a possible suicide. Treatment is divided into five progressive stages:—

a. Drugs.
b. Local application.
c. Galvanism.
d. Climate (change of).
e. Operative.

The drugs which are generally used are a large dose of quinine once a day, aspirin or phenacetin, salicylates, and two drugs which are specifics, viz.: tinct. of gelsemium and butyl-chloral-hydrate.

The following local applications may be used as counter-irritants: menthol in oil, aconite ointment, the ethyl-chloride spray, and a proprietary article known as antiphlogistine.

Galvanism is rarely of use; when employed a constant current should be used, the anode being placed over the painful spot and the cathode on the neck or spine.

This treatment must extend over some weeks to be of any use. As to environment some patients are benefited by removal to a warm sunny climate. Finally, we come to operative measures; minor operations are nerve stretching and resecting.

These methods usually afford but temporary relief, and it may be necessary to have recourse to an operation which, although drastic in character, has the merit of providing a lasting cure. I refer to the removal of the Gasserian ganglion on the affected side. Professor Rose successfully attempted to reach the ganglion through

the base of the skull, but the method which has now been generally adopted is the one introduced independently by Krause and Hartley, and now known as the Krause-Hartley operation. The technique is as follows :—

A flap having its base at the Zygoma is turned down over temporal fossa ; an opening through the skull is then made of such size as to expose the temporo-sphenoidal lobe of the brain. The dura mater is detached from the floor of the middle fossa and the temporo-sphenoidal lobe held up by a retractor. The middle meningeal artery passing through the foramen spinosum has now to be dealt with.

Krause ligatures and divides it but many operators plug the foramen. The foramina ovale and rotundum are now seen, the cavum Meckelii is opened and the ganglion freed. It is drawn upwards and extracted from its concavity. The whole ganglion with its root is turned forward. The second and third divisions are cut close to their foramina, but in order to avoid injury to the fourth and sixth nerves, lying in such close proximity the first or Ophthalmic division is cut close to the ganglion. This operation may be subsequently attended by unfortunate eye lesions, on account of the anæsthetic eye being unable to appreciate the presence of irritating foreign bodies. To avoid this, some operators leave the first division intact whilst others stitch together the eyelids before operating. Despite the skill of such specialists as Sir Victor Horsley (who has had but two fatal results in more than 250 operations) excision of the ganglion is a serious surgical procedure, and in 1913 Schlösser suggested the injection of alcohol in the branches of the nerve where they leave the cranium.

A needle is thrust through the cheek following definite landmarks until the foramen rotundum or ovale is reached ; alcohol is then injected either alone or with stovaine, eucaine, or similar local anæsthetic. Relief for some twelve months and even a cure is sometimes obtained by this method, which is the most modern treatment available. As showing that neuralgia major is of dental importance I would quote Rollinson-Whittaker, who maintains that it is always accompanied by arterio-sclerosis, and in 90 per cent. of cases is a result of oral sepsis. I will not dwell longer on the subject of neuralgia major other than to mention the fact that in diagnosis it is often difficult to distinguish a major neuralgia from a neuralgia due to some organic lesion of the nerve or its root. Such a neuralgia might be caused by pressure following a compound fracture of the skull, a meningeal tumour, and especially parasyphilitic nodes or gummata of the meninges. Having thus indicated a brief outline of the graver type of neuralgia (for but an outline it assuredly is), I would draw your attention to the minor type, a condition which is presented to some of us almost every day of our lives in the Dental Department. Under this heading one includes the term odontalgia. Pain from visceral disease may be classified under three heads.

The first, local: that is, in the diseased part. The second ; referred to the terminations of some nerve trunk involved in the disease. Whilst in the third : pain may be conducted up the sensory fibres of the sympathetic and then referred to the peripheral distribution on the surface of the body of those nerves whose fibres enter the same segment.

Under the first heading, local pain, we class odontalgia, which is pain referred to a particular tooth. Let us first deal somewhat in detail with this condition. Odontalgia may be either local or referred. Local odontalgia is pain in or around a tooth or teeth which are themselves the seat of the trouble. Referred odontalgia, on the contrary, is pain felt in or around a tooth which is not the seat of the mischief. Local odontalgia may be either acute or chronic, and for practical purposes has its origin in the pulp or the periodontal membrane. The acute condition is thus brought about by acute pulpitis or periodontitis. The differential diagnosis is comparatively easy. In acute pulpitis the pain is sharp, shooting, throbbing in character, whilst in acute periodontitis it is of the dull gnawing type. Alterations of temperature give rise to greater paroxysms of pain in acute pulpitis, which is also indicated by pressure on a piece of cotton-wool in the cavity (if one exists) giving pain.

Acute periodontitis is generally accompanied by a tenderness of the tooth when tapped or when pressure is applied and the absence of pain on the application of extremes of temperature limited to the tooth. The appropriate treatment which is adopted for the relief of these neuralgic pains is, no doubt, familiar to you all. Sedatives such as eugenol, oil of cloves, or carbolic for the pulpitis; and counter irritants such as aconite and iodine, tincture of iodine or capsicum plasters for the periodontitis.

In the chronic forms of odontalgia we have the chronic pulpitis in which pain at irregular intervals and less intense than in the acute form has a tendency to follow the course of the nerve. The treatment in these cases is similar to that adopted in the acute form. Of course the pulp may have died, decomposed, and be giving off gases which if unable to escape will exert pressure on the nerve endings.

Pain thus caused is relieved by freely opening the cavity and the use of antiseptics and neutralising agents such as tricresol, and formalin, oxpara, paraform, etc.

Chronic odontalgia due to periodontal trouble gives rise to grumbling sensations around the tooth, swollen and hyperæmic gums, continual and dull pain, as opposed to the paroxysmal outbursts of pulpitis.

In connection with morbid conditions of the periodontal membrane, it would be well to mention a cause of pain which is apt to be overlooked. I refer to the absorption of the interdental septa giving rise to pockets which permit of the collection and wedging of food with consequent pain in mastication.

In dealing with referred odontalgia (a condition brought about by peripheral irritation, almost always of dental origin and never transmitted across the median line) a wide and interesting field is opened up. Thus, a carious mandibular molar may cause the most painful sensations in a maxillary molar or a premolar of the same jaw.

To illustrate this I would instance a case which came under my personal observation a few weeks back. A boy of 15 was sent to me with one of those hazy tickets we love to get, "Please find and treat cause of pain in upper left molar region." On examining the mouth I found a pin-point cavity in the upper 6 year molar which the boy was sure was the cause of his trouble. In the corresponding lower tooth, however, a compound cavity was threatening the pulp. I dressed this tooth, and on a second visit put in a well-insulated filling, which resulted in the whole trouble clearing up.

As to these referred pains, the most typical case is a diseased mandibular molar causing pain in one of the premolars of the same jaw, and next, that of a maxillary molar giving rise to symptoms in one of the lower molars. Of the causes of referred odontalgia other than those of dental origin, the most frequent are operations upon, and morbid conditions of, the eye, nose, or antrum, alimentary, or uterine disturbances, and such diatheses as rheumatism, gout, and syphilis. The examination of individual teeth necessary to clinch one's diagnosis so closely resemble those necessary in cases of minor neuralgia that I will consider them under that heading.

We are thus lead to the discussion of neuralgia minor, which is divided into two classes:—

(a) Visceral referred pain; and
(b) True neuralgia minor.

Under the first heading we have to deal with cutaneous tenderness. This may seem somewhat difficult of explanation, but Head, in a paper on the subject in "Allbutt's System of Medicine," which is well worthy of perusal, explains it as follows:—

Sensations proceeding from a diseased organ will set up disturbances in the segment to which they are conveyed. Any other sensory impulses coming to the same segment, for example, those from the skin, will be profoundly altered on the way to the brain, and thus a normal cutaneous stimulation may give rise to sensations of a very unpleasant character. This brings us to the consideration of Head's "Segmental Areas of Hyperæsthesia," which I have before referred to.

A precise knowledge of the site of these areas is unnecessary. All that we want to grasp is the relations of the individual teeth to them. Approximately they are as follows:—

Taking first the maxilla, the incisors are in relation with the fronto-nasal area, an area extending from the upper lip, past the inner canthus, and on to the forehead.

The canines and first pre-molars with the naso-labial area extending laterally along the upper lip; the first molar with the maxillary area covering the cheek, below and to the inner side of the orbit, and the posterior molars—the mandibular area extending from the angle of the mouth backwards and upwards along the lower border of the maxilla to the ear.

In the lower jaw the incisors, canines, and first premolars are in connection with the mental or chin area, whilst the three molars will give rise to pain in the hyoid region running along the lower mandibular border to the ear, and the third molar may cause symptoms in the superior laryngeal region. In both jaws the second premolars give rise to tenderness of doubtful location. True neuralgia minor more closely resembles neuralgia major, and pain is of the darting, shooting type, with little or no cutaneous tenderness. Any dental trouble and such conditions as rheumatism, anæmia, and fatigue tending to lower the resistance of the tissues are prolific causes of minor neuralgia.

Correct diagnosis is important, and examinations must be systematic. As showing the importance of accurate diagnosis in such cases it is recorded that a medical man having to treat a case which gave rise to painful ear symptoms, operated and removed a perfectly healthy membrana tympani, entirely overlooking an exposed mandibular second permanent molar which was the real cause of the trouble.

Certain pathological conditions, nevertheless, may give rise to neuralgic symptoms. Of these anæmia is the most potent factor. In anæmic patients neuralgias out of all proportion to the exciting cause may make their appearance. Caries of a tooth may be the cause, but, on the other hand, dental symptoms may be caused by such conditions as menstruation, pregnancy, and hypermetropia (or long sightedness). Other conditions which may give rise to pain simulating that of dental origin are diabetes, malaria fever, hysteria, and neurasthenia, epilepsy, and insanity, and certain diseases of the eye, nose, ear, and tongue. In the eye, glaucoma, iritis, astigmatism, and hypermetropia, but rarely or never myopia (or short sightedness) may simulate pain in the maxillary teeth. As to the ear, pain in the hyoid region may occur. This is especially the case in otitis media, or middle ear disease. Suppuration exerts pressure on the tympanum, and the result is pain following the nerve trunk. Affections of the tongue which may result in pain of the dental type are gummata and malignant diseases, and the site of the pain is one of three situations:—

(a) The mental area in disease of the anterior portion.
(b) The hyoid area in disease of the lateral part.
(c) The occipital when the lesion is at the dorsum.

Rhinological causes are enlarged turbinates, antral disease, necrosis of the nasal bones in syphilis, and all catarrhal conditions.

Coming to the true dental causes of minor neuralgia first and foremost we have caries with its accompanying pulp trouble. The treatment is usually obvious, but in passing I would suggest that Silver Nitrate is not used in many cases where it would be of the utmost value. Some interstitial and sub-gingival cavities are very difficult to discover. To detect them use a probe all round the tooth and under the gum, pass floss silk between the teeth and see if it comes out torn or jagged as this will frequently disclose a hidden cavity. Metal fillings too near the pulp are another prolific cause of neuralgic pain. In these cases *always* suspect a large metal filling.

Such losses of structure and consequent exposure of the nerve fibres as are found in erosion, abrasion, attrition, and exposure of the cementum frequently cause neuralgia periodontitis, especially the chronic form resulting in exostosis is a prime factor in giving trouble. Buried roots and the sequela of extraction are rarer forms. Cases are mentioned where the inferior dental nerve has passed through the root of a lower third molar, and has consequently been ruptured in extraction, while the nerve endings may be pressed upon by the granulation at the bottom of the socket. Erupting teeth give pain at all ages—lancing the gums and lotio acidi boraci relieves the young patient, whilst later the erupting third molar is usually the seat of the trouble and has to be extracted. In this connection it is well to remember that the second molar is frequently absorbed by the oncoming third. Finally, we have growths, odontones, and cysts. These are generally obvious, and the treatment is to remove them. The medicinal treatment available is to give Aspirin and Phenacetin (5—10 gr.) every three hours, Tincture of Gelseminum (5—15 mm.) every four hours, Butyl Chloral Hydrate (5—20 gr.) every four hours, or Nitro-glycerine or Trinitrin ($\frac{1}{100}$ to $\frac{1}{50}$ gr.) three times a day, and general tonics such as Mist. Acidi. Co. (ʒi t.d.s.) of the Guy's Hospital Pharmacopœia.

To sum up and go over the steps—in examining the teeth for a possible cause of neuralgia I would say :—

1. Probe all round teeth and pass silk between.

2. Tap and press all teeth to exclude periodontal trouble.

3. Test each tooth with heat and cold: for heat, use a ball of base plate gutta-percha; for cold, the ethyl chloride spray, as in both these methods the individual tooth can be tested. This will show if the teeth are dead, or if they are alive, and the seat of the mischief will set up an obvious outburst of pain.

4. Look to see if the wisdom teeth are erupted.

5. Note the position of the pain which is roughly as follows:—From upper teeth, supra- and infra-orbital; and from the lower teeth, ear, neck, and shoulder. Failing all these tests look elsewhere.

Gentlemen, having thus discussed the subject at some length I will detain you but a few minutes longer while I record one or two typical cases which I have personally had the care of.

The first was a woman of 35, who had pyorrhœa alveolaris, and consequent exposure of cementum in the right lower molars. This caused considerable pain in the hyoid region, which cleared up on the silver nitrate treatment being adopted.

The second, a woman of 55, who had a carious lower right wisdom which caused referred pain in the corresponding upper tooth. I extracted the carious tooth, and her pain immediately ceased.

The third was a healthy man of 30, whose case was peculiar, inasmuch as he had pain in the naso-labial region as a result of a carious lower wisdom tooth.

The fourth, a woman, had a swelling in the upper right maxillary region accompanied by severe pain. This turned out to be due to the presence of a dental cyst.

The fifth was a young woman of about 22, who had pain referred from a maxillary to a mandibular wisdom tooth.

The sixth and last case is one which has somewhat nonplussed me, and is one on which I would ask your opinion. The patient is aged 26, and has suffered from an obscure skin disease since she was seven years old. Dr. Iredell assures me that this should have no bearing on the dental condition except from the fact that it has made her very neurotic. All her teeth are alive and sound, there is no periodontal trouble, or recession of gums, and in fact the most careful scrutiny has failed to offer any solution, nevertheless she has had a good deal of pain in all her upper incisors. What can this be due to? I have formed my opinion and will disclose it later.

Gentlemen, I fear that I have occupied you already for too great awhile, and only hope that you may have some energy left to carry on a fierce discussion.

Correspondence.

To the Editor of Guy's Hospital Gazette.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—Ed., G.H.G.]

Dear Sir,—As an old Guy's man who has always taken the keenest interest in the Rugby XV., I witnessed the match versus United Services at Portsmouth on November 19th, and should like to venture a few remarks upon the game in question.

Territorially the Hospital XV. had the best of the argument, but seemed unable to drive home their attack, whilst the Services' backs always seemed dangerous. The Guy's forwards played a fine game, but in the break away one man was always conspicuous, and rarely properly supported. The heeling and wheeling alike were admirable, and with chances innumerable the backs failed to score more than a solitary try. Their passing was none too accurate, their tactics quite obvious, their

wing men invariably being bored in touch, with not five yards gained. The Services' backs repeatedly cut through and made good openings for their wing threes.

In view of the approaching Cup Ties, Guy's must *tackle low* (it was sad to see a man passing the ball accurately with a Guy's man on his back, or anywhere but round his legs); the backs must *run straight*—not pass for passing's sake—and should be on the move when the ball quits the scrum half's hands, not standing stock still. Guy's men of ten years ago will remember how much the team in "Teddy" Morgan's days owed its scoring powers to the brainy work of O. V. Payne at half and A. B. O'Brien at centre, the latter the finest maker of openings I have ever seen.

The Guy's XV. has the makings of a really great side, but high tackles and cross running never spell danger except to those who indulge in them.—I beg to remain, Sir, yours faithfully, "OLD GUYITE."

Another Ballad of Motor Cycling.

Oh, lucky man, whose optimistic muse
The joys alone of motoring does choose
As theme of song; hear me! whose muse distraught
Can dwell but on the sorrows of the sport.
How setting out one morning fair from Guy's,
Without a cloud appearing in the skies,
Yet ere into the country I had gained
Those clouds came up and, dash it, how it rained.
How wet I got! and grimed with London soot.
Also the current "shorted" through my boot,
Giving me pins and needles; even worse
It made the engine miss and me to curse.
And when at length I got into those pleasant
Lands where the mangolds are destroyed by pheasant
Or other kind of game, my tyre burst—
Back tyre, too! a grizzly task to face
Alone and soaked that tyre to replace.
At last it's done, and also now at last
The rain has ceased, the clouds have hurried past.
Let in the clutch, then change, now fortune smiles—
She's running sweetly putting by the miles.
Oh! now, indeed, I know those joys you showed
With "open throttle on a country road."
But not for long. While passing by some trees
Out jumps a policeman, "Name and license, please.
"Just thirty miles an hour I should say.
"Three pounds will be about the fine you'll pay.
"Where do you live, and what's your destination?"
I answer, "To the nearest railway station."

Gazette Special Pathologist.

C.E.M.J., Cottage Hospital, Alton, Hants.—This is a malignant growth of the Breast, having the structure of a Scirrhus Carcinoma. It is composed of branching epithelial alveoli in a fibrous stroma, and shows areas of colloid of myxomatous degeneration.

PATHOLOGIST.

Papers received.—Nursing Times, Clinical Excerpts, St. Thomas's Hospital Gazette, St. Mary's Hospital Gazette, St. George's Hospital Gazette, Clinical Journal, Hospital, University College Hospital Magazine.

Reviews, etc.

Synopsis of Midwifery. Aleck. W. Bourne, B.A., M.B., B.C. Camb., F.R.C.S. Eng. (John Wright & Sons, Ltd., Bristol.)

The author describes this handbook as "an attempt to set the principal points of obstetrics before students preparing for qualifying examinations in a simple and concise manner." In the general plan of the book he has followed Dr. Eden's text-book on midwifery and the works of other authorities have been consulted on various points.

The essentials of midwifery are skilfully packed into the small space of 200 pages. Nothing of fundamental importance is omitted, and controversial matters are dealt with fairly. At the same time, while commending the author for satisfactorily achieving his object, we cannot help feeling that the work reflects greater credit upon him for his ingenuity than for a proper appreciation of his position as a teacher.

Obstetrics—so largely an art—cannot be taught by methods applicable to a subject such as pharmacy. This book will be of no use to the student who has not already a sound knowledge of midwifery, for he will be unable to fill in the gaps, but may be recommended to the candidate who desires a rapid and accurate survey of the subject prior to an examination taken after his qualification.

Diet in Dyspepsia. By William Tibbles, M.D., Medical Officer of Health for Melton Mowbray Rural District. (The Scientific Press, Ltd.) Price 2s. 6d. net.

A collection in book form of a series of lectures which originally appeared in the *Nursing Mirror*, and although intended primarily for the use of nurses, certain chapters should prove of great value to Junior Practitioners and Students. Even the most diligent medical Ward Clerk is liable to miss, altogether, the dietetic treatment of disordered alimentary function, and as this condition is so common in medical practice this book will supply him with a real need. We especially recommend the chapters dealing with the Relief of Vomiting, the Treatment of Acid Dyspepsia, Cancer of the Stomach, and Intestinal Indigestion.

We have received the October number of Lewis's Quarterly List of New Books and New Editions added to the Medical and Scientific Circulating Library. It contains the books which have been published and added to the Library during the months of July, August, and September.

These are not the busiest months for the publisher, and consequently the list does not contain quite so many important works as usual.

Amongst the new books we notice Gordon's Hyde Lecture on "The Place of Climatology in Medicine," and Lees' Bradshaw Lecture on "Incipient Pulmonary

Tuberculosis"; also "Diseases of the Stomach," by G. R. Lockwood, Poynton and Paine's "Researches on Rheumatism." Amongst the new editions of well-known books may be mentioned the new Gray's "Anatomy," Muir and Ritchie's "Bacteriology," a new Binnie's "Operative Surgery," the sixth, containing upwards of 100 new illustrations, Halliburton's "Physiology," etc. Short notices are given to the more important books, and the list forms a useful guide to the scientific publications for the period covered.

The November issue of the *Prescriber* is a special number devoted entirely to tuberculin in its therapeutic aspect. There are several articles by well-known authorities, and in addition there is a valuable critical review of all the various forms of tuberculin. Finally there is a list of recent books on the subject. We can congratulate the editor on having produced a very interesting number which will be of considerable value to all who are interested in the therapeutics of tuberculin—and who is not?

The *Prescriber* may be obtained from Mr. H. K. Lewis, 136, Gower Street, W.C., price 1s. post free.

Post-Graduate Medical Work under the Patronage of the Free Organisation for Medical Courses at the University of Vienna, School Year, 1913—14. Williams & Norgate, 14, Henrietta Street, Covent Garden, W.C. Price 1s.

This booklet gives, as the title suggests, particulars of the various courses of post-graduate work in Vienna, and should be very valuable to anyone who is going abroad to work during the year.

Rugby Football.

GUY'S v. UNITED SERVICES.

On Wednesday, November 19th, the Hospital XV. went to Portsmouth to meet the United Services. Unfortunately Parry-Jones, Millett, and Danby could not go, neither could Curle, who was suffering from a bad arm. Some reserves duly called upon also found it impossible to make the journey, so that the team was scarcely representative. The Services were also below proper strength, but they managed to beat the Hospital by 16 points (made up by 2 goals 2 tries) to 3 points (1 try).

The Hospital forwards went off in fine style, but were soon sent back to their own half by a fine punt from Gardner. Then Davies, the International half, initiated a fine round of passing which ended in Owens scoring an unconverted try. Davies himself was the next try getter, Mackensie goaling from an easy position. Mackensie gained the next try, after Davies and Gardner had handled, and Harrison easily put on the extra points. Before the interval Guinness, Steyn, and Medlock were instrumental in gaining the Hospital's only try, the last named touching down.

The second half saw some excellent tackling on the part of the Guy's backs, but in attack they were very moderate. Just before the end Gardner put the Services further ahead with an unconverted try, the game ending as stated above. Team :—

GUY'S.—A. H. Harkness (back); S. S. L. Steyn, A. F. G. Guinness, A. F. Rook, J. McEvedy (three-quarters); L. R. Broster, C. H. Medlock (halves); C. Lane Roberts, M. Tweed, E. F. Llarena, C. H. Laver, G. F. Kidman, D. M. Whitcombe, A. Liebson, M. Munday (forwards).

GUY'S v. HARLEQUINS.

This match has become the great event of the season. At Honor Oak Park a great crowd assembled for it on Saturday, November 22nd. The stand was packed, and it is no exaggeration to say it could have been filled more than once again. Many were disappointed at being without a seat. The Harlequins had not Brougham or F. M. Stoop, but they had C. Thorne, the Cambridge blue, and G. H. Bickley as substitutes.

It was a very fine game indeed, beaten though the Hospital were eventually by 3 goals to 1 penalty goal and 1 try, 15 points to 6, but for all that, one little touch of fortune and we should have been on top.

The forwards were splendidly led by Roberts, who has seldom played a finer or more forceful game, and it was fitting that at the end of 15 minutes' play he should score a try, just a little wide for Medlock's kick. Still, the Hospital had the best of it as regards territory. Stoop several times got his three-quarters going, but Rook and Harkness tackled splendidly aided by Millett. Birkett and Thorne wanted a good deal of holding. The grand forward work combined with the vigilance of Broster and Medlock spoiled many of the Harlequins' attempts at opening up the game, but all at once the Harlequins shot ahead; Birkett gathered from a line out and dashed to the line, and Millett grassed him just too late to save a try—a fine effort by both. Stoop, immediately after, gave a perfect pass to Birkett, who in turn gave up to Lambert. Millett went for a tackle, but slipped up, and Lambert trotted to the posts. The same player converted both tries.

After change of ends the forwards got right down to the Harlequin line where a penalty was awarded us, Medlock goaling. Again the forwards pressed right on the line; another free kick fell to us, but the angle was far too awkward to make successful use of the penalty. Several sterling bits of defence work by practically all the backs kept the Harlequin three-quarters at bay. Then, following a good kick from Medlock, Guy's had a rare chance. The ball was passed to Harkness with Curle unmarked and the line at his mercy. Harkness hesitated, apparently with the idea of dropping a goal, but he was soon bustled,

and a fine chance was lost. Before the end MacIntyre retired hurt, following a grand save on Millett's part, but the Harlequins through Milton scored another try, Lambert easily goaling. Team:—

GUY'S.—H. Millett (back); S. S. L. Steyn, A. F. Rook, A. H. Harkness, C. L. Curle (three-quarters); L. R. Broster, C. H. Medlock (halves); C. S. L. Roberts, O. Parry-Jones, A. B. Danby, A. Liebson, E. F. Llarena, C. H. Laver, D. M. Whitcombe, G. F. Kidman (forwards).

REMARKS.—A great game, grandly played. The forwards were splendid. All did well. Llarena tackled finely. Kidman will add further to his usefulness by going harder when he gets the ball in the loose. The backs have never tackled better or gone down so fearlessly, but the wing men must not be ignored. They seldom get a pass, although one knows the ball was purposely kept tight in this game. Still, Steyn and Curle should be given opportunities. They are both good men, and might or ought to have a chance of showing their worth. If either had had a show we might have won. Curle was unmarked when one of the few opportunities of scoring presented itself, and the ball was so often rushed past Lambert on the other wing that one longed to see Steyn in possession to complete the movement, or at least to attempt to do so.

UNITED HOSPITALS v. EDINBRO' UNIVERSITY.

This game was played at Edinburgh on Wednesday, November 26th, and many Guy's men, past and present, may be interested to know the result and to read a few remarks on this very entertaining struggle. It was one of the finest matches one could witness as far as play was concerned. The weather was not all that could be wished, but the players rose superior to weather conditions and gave of their very best. The first score fell to the London team, Steyn going right through the opposition to score a grand try. Medlock did not convert. Broster, when quite near the Edinburgh line, secured from a scrummage, and, feinting to pass, ran in close by the post for Medlock to easily put on the extra points. A free then fell to Edinburgh, who nearly scored, but soon after N. H. Coates secured the ball and got a good try, Fuller goaling, so that at half-time London led by 8 points to 5.

The second half opened with the Edinburgh backs passing and playing a better game. As play proceeded it was evident the onlookers were in for plenty of excitement, Mackenzie going over the London line and making, as there was no conversion, the scores level. Coates then scored again for Edinburgh, but no goal resulted. Immediately almost Roberts gained an unconverted try for London, and again the scoring was level, Then Sparks, the Thomas three-quarter, came along with a try which Medlock successfully majorised. It now looked a certainty for London, but just before the end Coates scored yet again, and with the last kick of the match Fuller goaled. Final score: United Hospitals (London), 2 goals 2 tries, 16 points; Edinburgh University, 2 goals 2 tries, 16 points. Team:—

UNITED HOSPITALS.—H. Millett (Guy's) (back); S. S. L. Steyn (Guy's), C. W. Sparkes (Thomas), R. H. Williams (Bart.'s), W. A. Stewart (London) (three-quarters); L. R. Broster (Guy's), C. H. Medlock (Guy's), captain, (halves); C. S. L. Roberts (Guy's, J. V. Fiddian (Bart.'s), H. L. G. Hughes (University), G. T. C. Smyth (Westminster), J. C. Russell (London), A. S. Liebson (Guy's), H. L. Addison (Middlesex), G. F. Kidman (Guy's), (forwards).

GUY'S v. NORTHAMPTON.

On Saturday, November 29th, Guy's journeyed to Northampton, and did remarkably well by gaining a victory of 2 goals 2 tries to 2 tries, 16 points to 6, over the Midland team. It is many years since we gained a victory at the expense of Northampton; the team are to be heartily congratulated, especially as Laver and Curle could not make the journey. Whitcombe came into the side for Laver, and Steyn, going centre, left room for Mackenzie on the wing. Steyn saw more of the ball and proved himself a source of worry to the Northampton defence, while he was always doing something for Mackenzie, whose first appearance in the Hospital 1st XV. was distinctly promising.

Our forwards played another grand game, and through their energy Roberts was able to register a try for Guy's, thus opening the scoring. The equaliser soon came, Cook getting 3 points for the home side. At this stage half-time was taken.

Five minutes only of the final half had elapsed before Steyn ran in very cleverly, Medlock failing at goal. Bradshaw for Northampton looked all over a scorer just after, but Guy's were tackling well, Harkness being specially prominent in defence; but soon Bradshaw scored an unconverted try by the corner. Mackenzie was the next to put on a try for the Hospital. He was half tackled, but managed to successfully reach the line. Medlock was successful with the place, and he also landed a goal from a try gained by Kidman after strenuous forward play. Final score as above. Team:—

GUY'S.—H. Millett (back); J. Mackenzie, S. S. L. Steyn, A. H. Harkness, A. F. Rook (three-quarters); C. H. Medlock, L. R. Broster (halves); C. S. L. Roberts, O. Parry-Jones, M. Tweed, A. S. Liebson, E. F. Llarena, A. B. Danby, G. F. Kidman, D. W. Whitcombe (forwards).

REMARKS.—The whole side played a very fine game, the forwards showing plenty of spirit. Both halves were excellent; Medlock's pace magnificent, but on two occasions he just omitted that final determined spurt he usually shows. Harkness's defence has been mentioned. Millett was also very good indeed. Steyn played an excellent game, his new position improving matters considerably. The only criticism is that Medlock should receive more backing up in those fine runs of his.

Births.

DAWSON.—On November 27th, at Maiden Newton, Dorset, the wife of Reginald B. Dawson, M.R.C.S., L.R.C.P. (*née* Fraser), of a daughter (Aline Blanch).

HINDE.—On November 17th, at Gurney Court, Magdalen Street, Norwich, the wife of E. B. Hinde, M.B., B.C., of a daughter (Isobel Taylor).

THOMPSON.—On November 21st, the wife of Ralph Thompson, Ch.M., F.R.C.S., of a son.

G. T. M.

GUY'S HOSPITAL GAZETTE.

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Passim.

IT would be a break with tradition did we not offer our readers our heartiest Christmas wishes, and not least among them the wish that many of them may spend this season at the Guy's man's favourite Christmas resort—his own Hospital. It is our habit annually to declare that we believe that the occasion in question will be unique in its entertainments, the phrase "up to the usual high standard" being rarely left unemployed. But this year we have been more painstaking and have actually sent our reporter to interview one of the Residents to find out what is in very truth in store. "Yes, sir," said the Great Man, "I can promise you that at any rate the theatricals will be up to the average of former years—can you tell me of another rhyme to French?" Modestly disclaiming any such powers our reporter contrived to share a seat with some hundred advertisements for Pianolas and returned to the charge. "You must, indeed, find your share in such a momentous undertaking not a little exhausting," said our reporter ingenuously, hoping by a little human sympathy to open the oracle's lips: there was no answer, but another sheet was added to the pile of verses on the already heaped-up table. "Our great difficulty," said the Great Man, after a long and impressive pause, "is to reconcile amusement with propriety. Here is a batch of verses too innocent to be funny; and here," indicating a pile of vast dimensions, "are remarks too funny to be innocent. Our duty is to combine the two." Our reporter took advantage of the temporary relief of tension occasioned by this *bon mot* to reintroduce his original question. "In past years," it was replied, "we have had our successes and we have had our failures, yet the standard has on the whole been high. I do not anticipate any falling off." So on this high testimony we can certainly promise our readers that the entertainments will at any rate not disgrace the reputation of former years.

WE often wonder, by-the-bye, at the difference between the hospital student's regard for his teachers and that paid by the undergraduate to his dons. The same difference, with modifications, is in evidence at most hospitals. Yet, at first sight, it is not easy to see the reason of it. The modern fellow of a college is not necessarily a cloistered recluse, nor essentially disreputable in appearance; nor is every member elected to the Staff of a hospital possessed of the vague and yet somehow definite qualities which are supposed to appeal to the average young man. And yet, with exceptions, the

don is a failure in the treatment of young men, while a member of the Staff is, as a rule, a success. Does the difference lie chiefly in the teachers or in the taught? We are not disposed to glorify the physician or surgeon at the expense of the don. For the authority of the member of the Staff is greater in that what he teaches must be learnt, while the other offers what may or may not be learnt —interesting educative stuff perhaps, but non-essential. Probably, however, the real reason lies in the fact that the medical student is a soberer-minded man—in spite of his reputation to the contrary—than his contemporaries in other paths of life. If his occasional outbursts are rather wild—and we can remember a certain periodical took violent exception to the doings on the occasion of the last Hospital Rugby Final —they are merely reactions against a sobriety which is beyond his years. He has began his life's work early, and has felt the appeal of pain and poverty; he has his responsibilities small at first, but gradually increasing. And there are some who begin to exercise what we may call—for let us handle it tenderly—a budding diplomacy; full of promise, for in these days merit cannot despise the stepping-stones. Who has not on his conscience once, perhaps,—only once—asking a question of his chief rather for the exhibition of his own profound earnestness than for the acquirement of new knowledge? Let him that is guiltless take up the stone. And the front seats at lectures—are they chiefly occupied by those of least acute hearing? Are dressings ever done more vigorously under the master's eye? But enough, we are too full of questions. Still, we would only prove that the fine art of diplomacy is not dead among us; not a very subtle diplomacy, our enemies might say; and in extolling it we must admit the possibility that the great ones are not always deceived.

The death of Mr. R. M. Wingent comes as a great shock to the Hospital and to the great body of old Guy's men who knew him personally. To the past Editors of this Journal he has proved himself a good friend; and our readers have for many years applauded the skill of a pen that has yielded a multitude of clever drawings and articles of unique interest to the Hospital. We have left the telling of his life to one who knew him better than we, and yet we would pay our tribute in suggesting that some permanent memorial of him be set up. What form this memorial should take we will leave to our readers and to the Hospital—and yet what more fitting than a memorial in connection with the Gazette Museum of Antiquities, which largely owes its being to his energies, and of which he was the first curator? And, personally, Guy's men will remember a man of an unfailing kindliness of heart that won him somewhat more than popularity; and of a patient cheerfulness in a life all too full of suffering.

We regret to announce that another familiar figure, well known to many generations of House Officers, has just passed away. Mr. Henry Williams, Clerk of the Hospital, whose obituary notice will be found in another column, was by far the oldest officer in the employ of the Governors, and a typical and picturesque representative of bygone days.

It can be truly said of him that throughout his fifty-two years' term he served the Hospital most faithfully through times of adversity and prosperity, and never made an enemy. By his death the Hospital loses an old and valued friend.

We are glad to notice the magnificent donation of £465,000, by which King Edward's Hospital Fund for London will benefit under the will of the late Sir Julius Wernher. Lord Rothschild, the honorary treasurer, in making the announcement at a meeting of the governers and general council of the fund, suggested that as the fund could not expect to receive such large amounts very often, the moneys should not be treated as ordinary legacies but should be invested permanently. This suggestion was supported by the Speaker of the House of Commons.

In recent years the Gazette has presented a series of pictures of men prominent in the past history of the Hospital and School. This year it has been decided to depart tem-

porarily from this scheme and to present instead a portrait of the late Mr. J. H. Targett. From a variety of causes it was not possible to get this portrait out immediately after Mr. Targett's death in May, and as we know that a large number of our readers would greatly appreciate a good likeness of their old chief, we have taken the present opportunity of publishing it.

WE regret that in our last issue we failed to insert the announcement of the Residents' Theatricals; these will be held on December 26th, 27th, and 29th in the Physiological Theatre. A few tickets are still to be had, and will be allotted to those who apply at once to the President of the Residents.

F. G. L. S.

Pass List.

University of Cambridge.

DEGREE OF M.D.

Nathan Mutch, M.A., M.B., B.C.

DEGREE OF M.B.

V. F. Soothill, B.A.

DEGREES CONFERRED.

M.B., B.C.: V. F. Soothill.

Royal College of Surgeons of England.

FIRST PROFESSIONAL EXAMINATION FOR THE DIPLOMA OF FELLOW.—NOVEMBER, 1913.

P. G. McEvedy. G. T. Mullally, M.B., B.S.
A. D. Marston.

SECOND PROFESSIONAL EXAMINATION FOR THE DIPLOMA OF FELLOW.

J. S. Bookless, M.B., B.S. J. T. Morrison.
E. G. Schlesinger, M.B., B.S., B.Sc.

Papers by Guy's Men.

H. M. M. Woodward and K. B. Clarke: Notes on Three Cases of Glanders.—*Lancet*, December 13, 1913.

E. Graham Little, M.D., F.R.C.S.: The University of London.—*British Medical Journal*, December 6, 1913.

Lawrie McGavin, F.R.C.S.: Flexion of Right Hip-Joint.—*Clinical Journal*, December 10, 1913.

E. G. Reeve: The Treatment of Phthisis by the Administration of Intensive Nascent Iodine.—*British Journal of Tuberculosis*, October, 1913.

Obituary.

HENRY WILLIAMS.

ON Sunday, December 7th, Henry Williams, Clerk to the Corporation of Guy's Hospital, passed away, within a few weeks of his seventieth birthday. After more than fifty-two years' service he died in harness, and during his last conscious hours talked of the Hospital for which he had laboured so long and so well.

From a Snapshot taken at the Prize Distribution, July, 1912.

He was the second son of the Rev. David Williams, Fellow of New College, Oxford, and Rector of Alton Barnes, Wiltshire. He was born at Alton Barnes Rectory, "in the wilds of Wiltshire" as he often said, and was one of a family of eleven children. At the early age of seven he left his parental home, to which except for holiday visits, he never returned, to

oin the Preparatory School for Christ's Hospital at Hertford, being transferred later to the school in London, where his education was completed. His recollection of his school days was very vivid, and he had many stories to tell of those early years. Leaving school at the age of fifteen, he was at once launched on business life with a large publishing house in the "Row," and settled in lodgings in the respectable neighbourhood of Pentonville. Heavy work and long hours, unrelieved in those days by a weekly half-holiday, severely taxed his strength, and, after an application to the London and County Bank, rejected on the score of health, he was introduced by an old friend of his father to Mr. Turner, the Treasurer of Guy's Hospital, and entered the Counting-House in June, 1861, as assistant to Mr. Shattock. His beautiful handwriting in the old books is a witness to the dignified leisure of those days, of which the tradition, somewhat unjustified of late years, still clings to the office.

On the retirement of Mr. Shattock in January, 1882, Mr. Williams was appointed to the senior post. The history of his long period of service is the history of the Hospital. The prosperous days of the 'sixties and early 'seventies gave place to the agricultural collapse of 1879, when income dropped one half, and 200 beds were closed. At the same time the nursing upheaval shook the institution to its foundations, and times of leisure in the Counting House were gone for ever. The first great appeal to the public in 1887 was conducted so effectively, with very little help, by Mr. Williams, that in about twelve months more than £100,000 was collected. Ten years later the appeal for re-endowment had his hearty co-operation, and the great extensions and enlarged activities made possible by these successful efforts he regarded with interest and approval, though with an occasional backward glance to the good old days when the hospital, moving in an uneventful course, "governed itself."

Everyone who has known Guy's Hospital in recent times will remember Mr. Williams. His long grey beard, his white hat in summer, his little shawl in winter, his charm of manner, made him a picturesque personality, prominent on all official or social occasions, recognized and beloved by all.

He was a man of strong social instincts, full of pleasant stories and reminiscences, the soul of geniality and kindliness, doing much good by stealth, and extending many a helping hand. He leaves an abiding and fragrant memory.

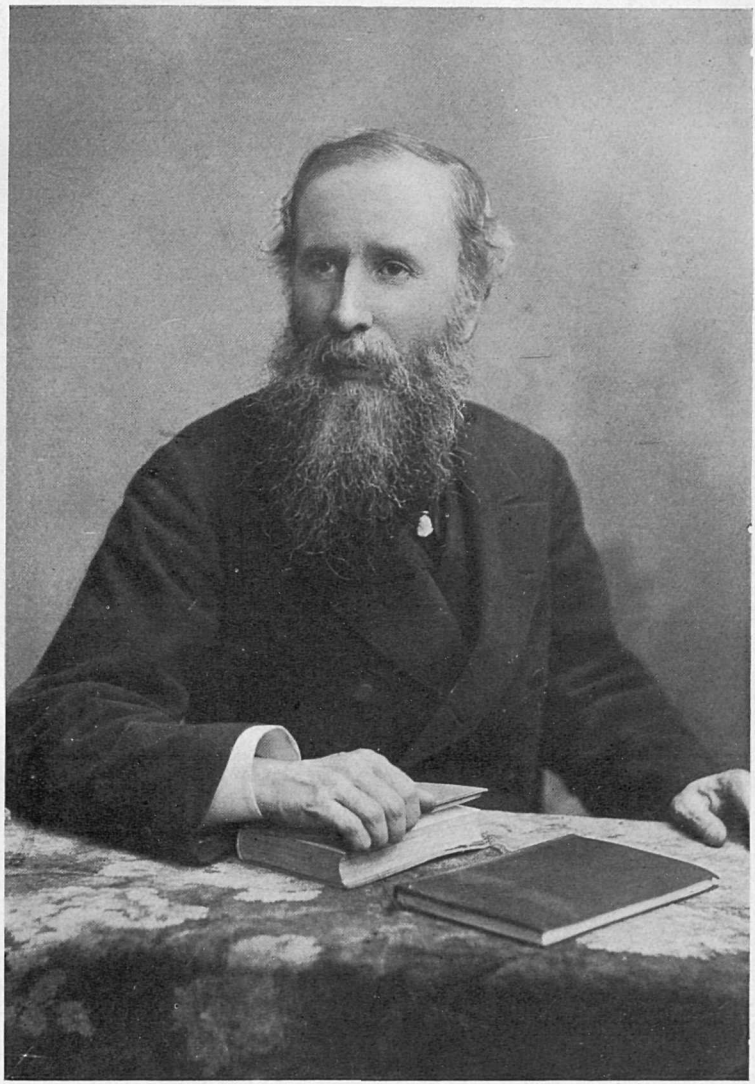
R. M. WINGENT.

An Appreciation.

There are very few men who have no enemies. There are fewer still who have only friends. And yet it is without hesitation that we place R. M. Wingent in the latter group; for in all our experience we can recall no other instance of a man who was so generally and genuinely appreciated, and even beloved, by the many with whom he came in contact. And since to be beloved is better than to be great we may, perhaps, account him as having been among the happiest of men.

That unconscious power of his of achieving friendships was certainly one of his greatest assets, as it was, we feel sure, one of his principal delights. No man came amiss to him; for all men he had the same smile. No vice or virtue seemed to disqualify an acquaintance for the larger prize of his friendship, and we have it from his own lips that one of his great desires was to know more men, that the number of those he looked upon as friends might be increased. If for that reason alone, the length of his sojourn at Guy's can have given him small real cause for cultivating regrets. But there were many other reasons which should have discountenanced any such tendency. The very fact of his friendliness, taken in conjunction with the sad physical disabilities under which he laboured, won for him a certain distinction. In the ordinary course of events an ordinary man would have been jocularly docketed, as a token of his long stay in the Hospital, with the label "chronic." That label was never really affixed to Wingent, since to each "year" in turn he appeared solely as an indispensable, kindly figure whose sentiments and enthusiasms were as much the sentiments and enthusiasms of that generation as they had been those of a previous generation. His friends were the students and residents of successive years, and it is in the memories of Guy's men and old Guy's men that he will find the warmest recognition and esteem.

We have no dates or references at hand from which to quote in regard to his Hospital career, but we know that it was entirely unsullied. Many of us wondered that he had ever permanently decided upon a career for which his mentality did not appear completely suited; and many of us admired him for his plucky efforts to proceed, in the face of the great obstacles which ill-health and misfortune placed in his



Henry Williams

Born 1843. *Died 1913.*

path, with the work which he had begun. When finally, as the result of aggravated ill-health, he decided to abandon medicine, none saw in his decision anything in the nature of a defeat; rather was his retirement regarded in the light of a well-earned respite from a brave endeavour.

Wingent will be long remembered for many things. He will be remembered for his genial face, and for his well-known figure—we can see him now walking with measured stride, and raised and slightly stooping shoulders, across the Park.

He will be remembered for his generous nature and for his lovable simplicity; no man was more generous and ungrudging. When success and realisation were not forthcoming for him, he was always the first to rejoice over the success of others. He will, perhaps, be most widely remembered as the GAZETTE artist and cartoonist. The Hospital, the Medical School, and the GAZETTE owe him a very deep debt of gratitude for the work which his pencil has performed on their behalf. With a wholly untutored hand he created, among others of less outstanding merit, numerous pictures relating in various ways to Guy or Guy's that must endure for all time as little masterpieces of topical event. Numerous editors of the GAZETTE can testify to his invaluable assistance. Christmas without a fresh series of Wingent's pictures is a sorrowful thought.

Again will he be recalled for his literary achievements. For many years he was a stalwart member of the GAZETTE Committee, and during the latter portion of his life he won new laurels in the character of writer and historian, for his series of articles on "The Borough and the Borough Hospitals," which have been republished in book form, have already taken their place, with "Wilks and Bettany," among the noteworthy chronicles and classics of Guy's. At the time of his death he was engaged upon another series dealing with "The Resurrectionists."

His antiquarian enthusiasm was great, and the hours he spent over research in the British Museum and elsewhere, in his zest for a proper completion of his work—though they were happy hours for him—may not have been wholly advisable considering the delicate state of his health.

His last and one of his finest achievements was the inauguration of a Museum of Guy's Antiquities in an annexe of the Wills Library. He was unanimously elected curator of this museum, which will continue to be regarded as "Wingent's Museum."

In all this untiring work of his ultimate day we can read two things. We can read his love for his particular pursuits, and, outweighing even that, we can read his love for Guy's. It is as a lover of Guy's that we shall especially cherish his memory. We believe that there has never been a man who loved the Hospital with quite such complete sincerity as Wingent. His labours with pen and pencil were pre-eminently labours of devotion, and in them, we think, he must have found that happiness which only the devoted experience. To have been to Guy's artist, historian, lover, all in one was surely to have attained to something higher and more honourable than fame.

We have spoken only of his outstanding distinctions; the knowledge of the details of his personal charm is shared among his many friends.

We have ventured above a belief that Wingent was among the happiest of men, and we repeat it now. For, in spite of all his tribulations and of sorrows, probably, which we know not of, the general impression which he gave to us was that of a man who took life as he found it, and who generally found it at its best.

We cannot even, in the midst of our loss, feel complete sorrow at his departure. Surely there was something of happiness, too, in that kindly release for his ailing body, and we are prone to imagine that the final attitude of his gentle mind towards the world of human events was not widely dissimilar from that quiet attitude expressed in the words of Walter Savage Landor's "Finis":—

> I strove with none, for none was worth my strife.
> Nature I loved and, next to Nature, Art:
> I warm'd both hands before the fire of life;
> It sinks, and I am ready to depart.

Gazette Special Pathologist.

H. L., MANCHESTER.—No gland tissue remains, but the section shows a malignant new growth of the nature of a scirrhus carcinoma simplex. The growth is composed of solid alveoli of spheroidal cells, and the individual alveoli are surrounded by dense masses of formed fibrous tissue. In places a certain amount of necrosis has taken place. The growth is apparently secondary to carcinoma of the Breast. PATHOLOGIST.

PAPERS RECEIVED.—Nursing Times Christmas Number, Medical Press and Circular, Hospital, Middlesex Hospital Journal, Polyclinic, Clinical Journal, Prescriber, Charing Cross Hospital Gazette, St. Bartholomew's Hospital Journal, New York State Journal of Medicine.

The Tabard Society.

A VERY successful meeting of the above Society was held in the Nurses' Home on Tuesday, November 11th. Mrs. Henry Fawcett, L.C.D., addressed the members on the subject of Women's Suffrage. Lady Perry was in the chair, and there was a large and enthusiastic audience of sisters and nurses as well as the wives of several members of the Staff. The proceedings were followed throughout with the greatest enthusiasm and interest.

Lady Perry introduced Mrs. Fawcett in a graceful speech in the course of which she referred to the great value of the work on behalf of women in which Mrs. Fawcett had so untiringly spent her energy during many years now.

Mrs. Fawcett, who was very cordially received, said that the Women's Suffrage should be looked at from the widest possible point of view, and not only as a political movement. It is a great human movement, one of the greatest ever known in the history of mankind; for former movements only affected a section or class of the community, this movement was to effect the position of all women. Not only in our own country, but in all parts of the world it was seen that the position of women is not what it was 15, 10, or even 5 years ago. Even the women of the East were asking for more freedom.

Perhaps the movement should also be classed as a religious one, for even in the days of Christ we find Him addressing women and discussing subjects of interest with them to the great surprise of His followers. Since then the position of women was almost one of degradation. The great democratic movements, the French Revolution, and in our own country the Reform Bills of 1832, 1867, and 1884 have secured the male population full parliamentary representation, and we ask that what has been found good and beneficial for men should also be given to women.

Some people are afraid of the freedom to be gained by this movement, but they are behind the times. They fear that if women get the suffrage they will immediately set aside all care and interest in children and childhood, but that is not so; these qualities will develop and grow and women will never weary of carrying out new ideas in the care of children. At the Women's Congress in Hull many suggestions were made on the subjects of the education, health, etc., of children, but legislation is necessary to carry them out, and here the disadvantage of the women's position is obvious, since they have no sure method of bringing pressure to bear upon the members of parliament until they get the vote.

Mrs. Fawcett then went on to refer to the Criminal Law Amendment Act and the Divorce Question. She also discussed the effects of Women's Suffrage in those countries and states which had given women the vote, and referred to the immense amount of support the movement was receiving in this country.

In conclusion, she said: "We do not believe in militantism, it is not right to overcome evil by evil, but we must overcome evil by good. None of the victories that have been won have been the result of violence, and we should value the means by which new employments and new professions have been thrown open to women. In other countries where women have the vote, violence has not been used on the part of the women, so we must endeavour not to force the movement by violence, but to appeal to the higher instincts of man.

Mrs. Lauriston Shaw referred to the fact that women were entitled to vote before the Reform Bill of 1832.

Nurse Gladstone asked would the vote be granted to all women or only to a small section.

Sister Sheldon deplored the fact that the suffrage movement at the present time was setting man against woman.

Mrs. Ormond thought women ought to put more energy into the work already open to them on Boards of Guardians and prove by their work their fitness for the vote.

The Matron moved a hearty vote of thanks to Mrs. Fawcett, which was seconded by Sister Sheldon, and Mrs. Fawcett replied.

The meeting then adjourned.

Guy's Hospital Debating Society.

A DEBATE was held on Thursday last in the Club Smoking Room. Owing to the energy of the man behind the scenes in the dissecting room, and possibly to the golden opportunity afforded by the subject for heaping contumely on one's friends, quite a number of members turned up.

Mr. POULTON proposed that in the opinion of the House, Scotchmen, Irishmen, Welshmen, and Colonials should be excluded from the Hospital. A big thing for a moderate Englishman to do, and one admires his courage. In a speech that was very subtle, but not too convincing, he told some very good stories, pleaded gently with the opposition for their own good, insisted that men should stay in their own countries, and raise the standard of their own medical schools and hospitals.

Mr. BEVAN-BROWN who followed, first electrified the chairman by shouting "Sir" in a terrible voice; proceeding, he poured forth adjective after adjective of contempt and invective against the Englishman who dared to arrogate to themselves alone the privilege of entering Guy's. Becoming quieter he waxed eloquent on the virtues of Welshmen, patted the Colonials on

the back, called them strong, fine, healthy fellows, and sat down amidst a hurricane of applause. Brown is certainly a speaker of originality. Like men less pleasing to listen to, he can say a great deal without saying anything, yet in such a way, with such ease and humour, with certain changes in tone and gesture, that the House would gladly hear him for the full twenty minutes allotted to the opposition speaker of the evening.

Mr. Guy, in supporting the motion, rather defeated his object by appealing to Englishmen alone. He disliked competition, confused Guy's with England, and generally went a little deep for a somewhat flippant audience. We imagine that when really roused he might sway multitudes, but not a House bent on being amused.

Mr. Biddle is a Welshman, which means everything or nothing according to the point of view. To him naturally it is everything, and in his speech, which was somewhat plaintive in tone, he endeavoured to make the House believe it.

Mr. Liebson kept the House in a ripple of merriment. In the vernacular he was simply rich. We know no member who has such a command of gentle satire, who is so simply eloquent, who literally plays with his audience, and thoroughly enjoys the fun.

Mr. Leviseur, or Dutchman, as his friends affectionately call him, hails presumably from the same Continent, but whether as a Colonial, Dutchman, Africander, we do not know. His speech did not enlighten us. He asked "What is life?" with an air of profound wisdom, took a puff of Boer tobacco, and told us "it was raw"; complimented the Englishman for standing on their own legs, told a delightfully humorous story of death, and sat down in the lap of Mr. Sampson, who, in consequence, immediately arose and addressed the House.

One day we shall hear of Sampson as a great Imperialist in the Union Parliament. His sentiments are magnificent, and his English so classical, that frequently he was obliged to stop and interpret his five syllable utterances. With Liebson, Leviseur, and himself, South Africa was excellently represented.

A host of Irishmen continued the debate. The redoubtable heavy-weight stretched himself to his full height, put out his chin, and made even the men by the fireplace shiver.

Mr. Kendle scorned to hit the Englishmen, already riddled with the invective of more than half the previous speakers, and contented himself with a few mild remarks.

Mr. Heath was just a little Johnsonian in manner, and inclined to be a little ponderous. He must not tell us so often the circumstances of his Anglicisation. No one would take him for a Welshman or a Maori. He succeeded in adding a good deal of argument to the English side.

One gentleman spoke a good deal in French, but as we alone could understand, we have not the conceit to report him.

Other speakers, including Mr. Costa Rica, addressed the House, but we must be excused if towards the end of the evening one envelope is crowded out with the reports of former speeches.

Dr. Mann, as usual, made a delightful chairman, which, after all, is the highest compliment one can pay to any occupant of the chair. The debate from the point of view of both attendance and speech-making was distinctly encouraging.

1893 to 1913.

Twenty years have just passed since I qualified. A short account of my varied experiences may, perchance, prove of interest to my contemporaries and act as an "'orrid warnin'" to the men who now rule in our stead. Well do I remember the sprays in the old Theatre, the smell of the carbolic, and the blazing spirit, Mr. Durham and other surgeons in fine old "frocker," rendered glorious by the dried relics of many an abscess and the spurtings of untold vessels. Dirty, but charming, old Front Surgery!

By the time I became H.-S. all the old manner had changed, and the modern, clean young men in aprons soaked in carbolic, with hands rendered like eagles' claws by the same chemical, became the ruling fashion. Well do I remember one of the present-day senior staff recounting to us an operation that had been performed on the previous day in Clinical in which he had seen a living man's liver and gall-bladder. Figure the change that has come upon us in twenty-two short years!

My first experience one week after qualification was assistant to a Londoner during the early days of influenza—that was a busy experience. Then I was obstetric resident to Drs. Galabin and Horrocks, and H.-S. to Mr. Golding-Bird. We worked hard; I suspect harder than to-day, as there were fewer officials to do the work. A H.-S. used—I know not now—to be the finest appointment imaginable, as *everything* that came into the Front Surgery was referred to him. A year in a poor London suburb, then a year and a half in a big poor law infirmary. If you wish to learn, to do surgery, to be boss, to work night and day, to see almost everything medical that can be dreamed of, go to a big poor law infirmary. Then get away to sea, for the human flesh and blood that you are will want it; go on a great liner and learn all sorts of conditions of men and places. Join the P. & O. and learn by personal observation the might and majesty of the British flag. Then back to the staid life that becomes your sobered years and senses. Learn to listen to your patients, perhaps for hours, you will learn something if only you can be patient; interject a remark now and then; one per cent. of the conversation is an un-

necessarily large amount. Be firm in your orders and desperately distinct. Avoid voicing opinions on any subject except the one for which you are called, and even then be very careful.

My experiences show many strange things, as do those of all my brethren. A young man at sea with very rapidly developing pyrexia and acute mania. The great Prof. Koch, who chanced to be on board, declared "It is the teephoid." I knew it was not; it was Malta fever, and in one week he was well. Despite the views of the surgeons you will see dozens of appendicitis cases that never offer a serious symptom; but, and the but is a very large sized "but," an odd case will suddenly develop symptoms that demand, nay, yell for, operation. A great percentage of sudden deaths will show nothing pathological at the post-mortem. A patient, particularly if it be a man, will scarcely ever be out of health for more than two or three weeks unless he have something seriously amiss with him; therefore, never leave a patient without examining him with the utmost care beyond the second visit.

A man, æt. 42, complained that he was "seedy," and had dyspepsia. Bismuth, etc., improved him; he returned to work. After three weeks he broke down again; he never hinted that he was unable to swallow his food, merely that he could not eat it as it disagreed with him—complaint, carcinoma of œsophagus.

A stout woman had banged her arm against the door some months previously; there was now a great tumour of the humerus confidently diagnosed as sarcoma by numerous surgeons at the College. The X-ray man declared against sarcoma; there were no bony spicules. Operation refused. One year later the arm was normal.

Beware of syphilis, it may be fifty years distant, as in the case of an old gentleman aged 70 years, whose violent headaches were cured with iodide.

Epilepsy has long, very long, recesses. A gentleman dining, suddenly fell down in a typical fit in the midst of laughter, the first sign for nearly twelve years. A publican had a severe fit; it was 25 years since there had been the last indication of epilepsy. Empyema is said in many, many books to be incurable unless the pus be thoroughly drained. A man of 68 had pneumonia. I subsequently drew off 9 oz. of odourless, green pus. He was doing well in every respect one month later.

Be hopeful of fractured skull bases. A man, æt. 28, had undoubted fracture through the cruciform plate of frontal bone. He was deeply comatose. In less than a month "he appears to have completely recovered."

Partial anuria may last for weeks and be dependent on a freely moveable right kidney. A young married woman who had suppression to 2-4 ozs. urine per diem for about six weeks. She was now very ill, vomiting, and a uræmic fit occurred. Sweating stimulated, and she recovered. On going upstairs a little while later *without* her belt, was taken with violent pain. I held her up by the legs, manipulated her abdomen, and instantly cured her pain.

Phthisis may have 45 years' history. A feeble, little, round-shouldered woman, æt. 65, had "howling" signs in her left lung. When twenty she had been laid up with a long attack of pleurisy on the left side.

Wild hysteria has often a serious basis. A girl had a mad, uncontrollable attack of hysteria; two days later we discovered a large ovarian tumour, of which she died on operation.

Tens of thousands of cases of vaccination are harmless, but in twenty years I have lost two cases, one of vaccinia gangrenosa and one of erythema multiforme, the vaccination "marks" appearing quite normal.

Inverted puerperal uterus occurred once in 250,000 confinements at the Rotunda. I have seen one, instantly returned; the woman recovered.

Mumps is a harmless disease, yet I saw two children with severe nephritis following an attack, the girl being very ill.

Unnumbered cases of dilatation and curetting are performed, yet I have known three with serious bleeding, lasting in two for many weeks.

Hysterical attacks will cause you great trouble and loss of reputation, but organically the most careful investigation will prove absence of disease. Remember that these diseases are very real to their owners.

Bone-setters and opticians are desperately dangerous persons. Here is a list of one bone-setter's escapades in one of my little practices: A syphilitic knee-joint wrenched—awful pain; a tubercular knee wrenched—hæmorrhage and eventual excision; a periostitis of humerus wrenched—ghastly pain; a fracture into the elbow-joint wrenched—my diagnosis disturbed and great injury done.

A tobacco amblyopia missed by a great Strand optician, and glasses fitted; an advancing glaucoma treated with belladonna fomentation and glasses! Having done a good deal of eye work, I am of the firm opinion that opticians are unsuited for their work without a long medical training. Optic atrophy treated with glasses is a no uncommon experience.

Tonsils and adenoids are operated on very cavalierly, but lately I have had two severe hæmorrhages, one from the tonsils of a young lady, one from the adenoids of a child. Circumcision performed with the utmost antiseptic care will give you infinite trouble at times. You scarcely learn it at hospital, but there is no operation, however trivial, that may not be your undoing. On one occasion I opened up a young man's mastoid and released some pus; his meningeal symptoms were scarcely relieved, and he died next morning. Result, my income was reduced to seven shillings per diem for nearly six months. On another occasion I wired a fractured patella and had the man out walking in five weeks. Result, the practice rose immensely. You will find some of the work fascinatingly interesting, but the financial result a poor one.

AN OLD H.-S.

Guy's Hospital Musical Society.

A Concert, given by the above Society, was held in the Physiological Theatre on Friday evening, 12th inst., and Mr. Denis Browne had drawn up a programme which was extremely ambitious. The attendance was moderate, and one would have liked to have seen more present, especially as the items were of more than average importance, and also from the fact that music forms an essential feature in the recreation of many of those connected with the Hospital.

There is, undoubtedly, much talent in this direction, and it was regrettable to see such a small chorus endeavouring to cope with the difficulties—and they are many—of choral works by Bach and Brahms. However, Mr. Denis Browne managed, by dint of some vigorous work with the *bâton*, to get interpretations of "How lovely are thy dwellings" (Brahms) taken from the Requiem, and the cantata "Sleepers, Wake!" (Bach), which were highly creditable to all concerned. The solos in the cantata were beautifully sung by Miss Gladys Moger, Mr. J. Stewart Wilson, and Mr. Clive Carey, and, although the acoustic properties of the theatre are far from perfect, yet it was possible to distinguish every word of the solo parts. The chorus might have attacked their parts with a little more vigour, and also—the usual fault—watched the conductor more. Mr. Wilson was in excellent voice, and sang with great effect "Tiger, Tiger," by Alan Gray.

The second part of the programme opened with "Soul of the World" (Purcell) by the chorus, and in this they showed evidence of having become thoroughly "tuned up." It was a delight to listen to, and the applause was well deserved.

Miss Gladys Moger sang with beautiful tone and perfect diction "Au pays où se fait la guerre," by Duparc, and to insistent demands she responded with an encore.

Miss Ursula Williams (who led the orchestra, and sustained the difficult solo violin "Obbligati" in the cantata with very good tone) and Mr. Carey joined forces in "A Fancy," composed by the latter for violin and pianoforte. This work, which is based on a Folk-tune, is essentially modern in its construction and fulfils the title given to it. It was well played, and at its conclusion both the *artistes* were recalled, the composer again returning to bow his acknowledgements.

Two songs from Grieg's "Sigurd Jorsalfar," for baritone solo and male voices, were rendered with fine effect. The solo was taken by Mr. O. Parry-Jones who has a pleasing voice, but the first was somewhat marred by persistent vibrato. He was well supported by the male chorus.

Mr. Denis Browne had set himself the task of playing Chopin's "Berceuse," but substituted Percy Grainger's arrangement (No. 6) of an Irish tune from County Derry —a charming but pathetic little melody—which he played with sympathetic tone and excellent technique, and on the audience requesting more, replied with a Brahms waltz (Op. 39, No. 2).

Mr. Carey again came forward as vocalist and sang "Weep you no more, sad Fountains," by John Dowland (1603) and "Whither runneth my Sweetheart?" by John Bartlet (1606). These two examples, composed by English musicians when Madrigal writing was enjoying highest favour, were beautifully sung and well received, the second being repeated. Dowland has been immortalised by Shakespeare in one of his sonnets:—

"Dowland to thee is dear, whose heavenly touch
Upon the lute doth ravish human sense."

The Concert concluded with a magnificent interpretation of Brahms' "Gipsy Songs," the solo parts being taken by Miss Moger and Mr. Wilson, who sang with their accustomed clearness of diction and accuracy of tone.

A word of praise is due to the orchestra for the admirable support they gave in the accompaniments of the various items in what was a most enjoyable concert, and it must have been gratifying to the Society to entertain an audience so enthusiastic.

In Lighter Vein.

A Guy's Decalogue.

i. Thou shalt love none other Hospital better than this.

ii. Thou shalt not make for thyself any coffee on night nor food of any kind that is in heaven above or in the earth beneath or in the water under the earth. Thou shalt not sit down when possible, nor rest, for the motto of the Hospital is "Progress," and Matron hateth all slackers.

iii. Thou shalt not speak home-truths of any of thy Sisters for the Matron lendeth not her ears to the "strings" of a lyre.

iv. Remember that thou wake not the patients before 6 a.m. (R.V.). Ten hours ought they to have for sleep, in which thou canst do all that thou hast to do. Of what thou leavest that shall the day nurses complain: for in the day they do no manner of work, they and their pro.'s and their wardmaids and the stranger that sometimes comes within their gates. Truly the night is the hour of rest, and the one Head Nurse blesses it.

v. Honour thy "super"(man) and matron that thy days may be happy in the land wherein thou strivest.

vi. Thou shalt do no murder—either by accidental hypodermics or infantile smothering.

vii. Thou shalt not entertain on Sister's week-ends.

viii. Thou shalt not steal either nurses' slippers or patients' pudding.

ix. Thou shalt not bear false witness against Div. I.

x. Thou shalt not covet thy neighbour's Division, thou shalt not covet thy neighbour's physician, nor her doctors, nor her ward clerks, nor her nurses, nor her patients, nor anything that is hers. N. M. H.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—ED., G.H.G.]

SIR,—Reading, this morning, "The Resurrectionists" in your issue of 6th December, I came across the following: "It would be useless to guess how frequently the burial service was read over a coffin load of brickbats by unsuspecting clergymen at this period—viz., 1825."

It may interest you to know that this occurred some 50 years later. When I was a student, Jim Hainsby was the dissecting room porter, and I had the following tale from him:

The school required a body for some purpose, it was frozen and sectioned, I believe. At that time, I don't know how it may be now, for each body there was a funeral. Jim kept a coffin in his evil smelling den, and every evening he collected anything which was no longer required from the dissecting room, and when the coffin was full and of an average weight, the hearse called, and the funeral started.

By this process a body might be buried in four or five coffins and go to earth, if not to heaven, in weekly numbers. The body, moreover, had to be buried within a specified time. These regulations could not be carried out in respect to the corpse in question.

But Jim was equal to the situation. He filled in a coffin of bricks, stones and saw dust, not to mention a dead cat which had been dissected. The shell was screwed down and the hearse came. It then occurred to Jim he would like to hear the service read over this collection. He followed as the only mourner, and followed on foot. He had an artificial leg, designed by himself, having suffered amputation very high up in the thigh. They were lowering the shell into the grave, it stopped, fell, and being a cheap concave, burst. The brick-bats, cats, etc., filled the grave, and Jim assured me that, despite his wooden leg, he made a record, getting out of the church-yard.

How far this may be true I can't say. I certainly heard it from Jim about 1869, and I believe it.—Yours truly,

GEORGE TURNER.

High Street,
Colyton, Devon.
13th December, 1913.

SIR,—The following account of the adventures of a medical man on the East Coast of Africa may interest your readers.

A young relative of mine, G.T., went on duty to a God-forsaken little port, at the mouth of a river, somewhere near Beira. He intended the following day to coast down to Delagoa Bay, and accordingly, just after dark, went on board the steamer, a craft about the size of a County Council Thames Steamer. There were no cabins or bunks, so he went into the saloon, locked the door to keep out Dagos, and curled up on the sofa. He had been asleep about an hour when there was a loud knocking; thinking it was only a Portuguese he took no notice. At last he recognised the voice of a man in his company's employment, and asked "What's up." "A most important message, a man is seriously ill at a compound five miles up the river and they want you." He went in a boat five miles up stream, in the dark, in a dense mist, in damp, steamy heat, with plenty of mosquitos and mud. Anyone who knows an African river will understand it was not a picnic. Arrived at the compound he found his patient asleep and, of course, did not rouse him. He learned he had only returned from Johannesburg about a fortnight; he had been sent there to be cured of malaria and had returned against the advice of his medical adviser.

Soon after daylight he was awake, collapsed and muttering. It was an awkward position; if he left his patient there was no doctor within miles; if he took him with him he might hasten his death. Finally he decided to adopt the second alternative, put the sufferer into the boat. They soon dropped down to the steamer. There was considerable difficulty in getting the patient over the side, and in the struggle the doctor was knocked overboard into what he described as "a concentrated solution of shark." By means of champagne and injections of strychna, the patient revived and for two days or so was comparatively well.

G.T. rubbed his hands and thought he would land his man alone. However, within twenty hours of Lorenzo Marquez the poor fellow collapsed and died. The obstructions of the Portuguese officials, all greedy for tips, having been overcome, the plasser explained that in Portugal it was usual to dress the body in its best clothes, he offered to do so and to coffin the corpse. The offer was gladly accepted and twenty shillings changed hands. G.T. attended the funeral and then went to the Cardusa Hotel to dinner.

Here he had a disagreeable surprise, the steward had made a mistake and had dressed the corpse in his G.T.'s, dress clothes!

That night was hot and stuffy, G.T. could not sleep. The hotel is on a cliff three hundred feet above the beach, so he strolled down, in pyjamas and slippers, and talked to a Dago policeman who was fishing from a pier. An hour or so later he decided to have a dip. Fetched a towel, undressed in a bathing hut, dived off the pier and had a swim. When he got out his friend, the policeman, promptly arrested him for bathing without costume (3.30). He was marched between four men with drums and swords through the streets to the jail and locked up in a cell. Several hours later he appeared before a magistrate. He pleaded ignorance and that no one but the policeman could see him. The policeman told the

magistrate he might have been seen from the top of the cliff. He was committed and sentenced to *fifteen days' hard labour*. However, on payment of thirty shillings he was released at 3.30 p.m. the same day, too late for his train to Johannesburg.

He must have been singularly ignorant of the Portuguese official. Half a crown put into the policeman's hand would have saved all trouble or fuss.—Yours truly,

GEORGE TURNER.

High Street,
Colyton, Devon.
13th December, 1913.

An Appeal on behalf of Mrs. Courtnay Milward.

DEAR SIR,—In conjunction with Miss Tunbrell, matron of the Lowestoft Hospital, I am endeavouring to raise some money to assist Mrs. Milward, who will be remembered to many Guy's nurses in the past as Nurse Freeman. The sudden and untimely death of her husband has left her in very straitened circumstances with three boys to educate and support.

Dr. Milward's colleagues have already responded most generously to an appeal made to them some months ago, and I feel sure Mrs. Milward's contemporaries at Guy's, did they know her present circumstances, would readily come forward and help.

We want to send the money to Mrs. Milward in the form of a Christmas or New Year's gift. A list of donations already received is appended. Further sums will be gratefully received by Mrs. Wilson Tyson, The Beeches, Lowestoft; or Miss Tunbrell, The Hospital, Lowestoft.

I would add that this movement has the hearty approval of the Matron of Guy's.—Yours truly,

MAUD TYSON.

The Beeches, Lowestoft.

Miss Bayliss, Nursing Home, Norwich ...	1	1	0
Miss Fox, Matron, Prince of Wales' Hospital, Tottenham	1	1	0
Mrs. Hugh Higgens (née Morrah), The Nursing Home, Winchester	2	2	0
Miss Hyland, Matron, Devonshire Hospital, Buxton	0	2	0
Miss Livermore	0	2	6
Mrs. Pike (née Markland), York Terrace, Cheltenham	1	1	0
Mrs. E. W. S. Rowland (née Graham), Western Elms Lodge, Reading	0	10	6
Mrs. Wilson Tyson (née Witherington) ...	0	10	6
Miss Tunbrell	0	10	0
Miss L. Taylor, Clifton Road, Rugby ...	0	10	0
	£7	10	6

DEAR SIR,—May I make the suggestion through your columns that it is time that the Hospital had a conveyance of its own for bringing cases from the district to the Hospital.

I have heard from the Externs, and have experienced myself, the great difficulty there is in procuring a cab or taxi to bring a case up; it is generally necessary to go to one of the railway stations before one can be found, and then, more often than not they refuse to go to the case; between the hours of 1 and 6 a.m. it is practically impossible to get any conveyance at all, it being necessary to wait till 6 a.m. when the taxis come out from the garages.

The waiting involved in looking for a cab adds an additional risk to the mother and child, which could be obviated if the Hospital had a cab of its own.

The Hospital, I think, would save in the long run by such an arrangement, as the money that is now yearly spent on cab fares would be saved; besides which the cab could be used for sending patients from the Front to the Infirmary, when not in use on the District.—Yours truly,

AN OLD EXTERN.

Abstract of Report of the Board of the Faculty of Medicine upon the Final Report of the Royal Commission on University Education in London.

The Board agree with the Commissioners that the possession of a medical degree in the University should, for the present at least, continue to confer the right to practise (sections 312-315 and 334). It recognises, however, the distinct limitations in the subjects and methods of instruction necessitated by such an arrangement, and would welcome the day when by common consent all British Universities would agree to forego this doubtful privilege.

The Board believes that many of the junior men, given freedom, opportunity, and further financial assistance, would devote themselves with energy and enthusiasm to research.

The criticism that the present system of promotion is close, and goes too much by seniority, is, in the opinion of the Board, to a certain extent justified; but it believes that with all its disadvantages the system of promotion by seniority has in general proved satisfactory, especially with regard to the teaching of clinical subjects in which long experience is of such great value. Great care is exercised in the selection of candidates for junior appointments, and occasionally promotion by seniority is interrupted by importations from without; while holding these appointments the men have an opportunity of proving their capacity. The practical advantage conferred by seniority is often quite small, and disappears in the presence of outstanding merit in the juniors.

With reference to the form of teaching, the Commissioners have expressed a strong preference for that known as the clinical demonstration or lecture (section 257). This system of teaching has distinct limitations. It may be possible to demonstrate certain diseases, such as those of the nervous system, before a large body of students, but it is quite impossible to pursue the same course, if the teaching is to be useful, in the case of such diseases as those of the heart or lungs or of the alimentary canal. Some surgical diseases may be usefully demonstrated before a large audience, but in the majority of cases true clinical instruction necessitates the intimate investigation of the patient by the student. The same is true with regard to almost all cases of gynæcology.

This is the form of teaching which has naturally developed in London owing to the wealth of clinical material and the number of teachers available. It is the subject of envy on the Continent and in America, and the proposal to override this system by another, of which the superiority is not proved, is one which the Board cannot advise the Faculty of Medicine to accept.

It is important to remember that research should not be confined to the laboratory. It is a matter of common knowledge that clinical research of the highest type has been conducted in the face of difficulties by clinicians. For them disease and not man has planned the experiment, and they have investigated the result. It has been urged that no clinician has made any discovery of importance in recent years (Minutes of Evidence, July 28th, 1911, page 359). Recent advances in knowledge of the diseases of the nervous system and of the heart alone are a sufficient contradiction of this statement.

The Board, therefore, is of the opinion that if professors be appointed, they should not be permitted to engage in private practice.

The Board is of the opinion that the University atmosphere would be best created in a medical school by the encouragement of those who seem to possess the necessary qualifications to pursue research untramelled by the necessity for earning their daily bread, and that this end could be obtained with the least disturbance of existing methods by the appointment in each medical school of one or more professors of advanced medical subjects. These professors should devote considerable time to the organisation of research, and should give a certain amount of teaching of the academic type. The more technical aspect of the student's education would be left in the hands of the present clinicians, who should be encouraged and aided in their endeavours to advance the knowledge of the subject which they teach. These clinicians, according to their merit, might be awarded as academic distinction the title of "associate professor," "reader," or "University teacher."

The Board is of the opinion that it is undesirable to limit the scope of University influence by confining medical teaching of the University type in London to not more than three colleges, and thinks that any school or college that can provide instruction in conformity with the ideal of the University should be permitted and encouraged to do so.

"Points sans Points."

Conversation supposed to have taken place between a fresh Clinical and his Physician.

Physician: "Well, how's Clinical and the neurotic woman you've just admitted?"

Clinical: "Oh! I don't know what to make of her: if it had been July or August I might have called it query gastro-enteritis, but December—well, she's a bit of a puzzle."

Physician: "What do you intend to do with her?"

Clinical: "Oh! Cooper up a bit, and put her on Perry."

Physician: "What does she have in the night?"

Clinical: "Arabella—and arrowroot."

Physician: "Have you found anything of her history? Has she been laid-up at home? And where does she live?"

Clinical: "She lives in just an ordinary town-row of houses in Bromley. Her husband used to be a Steward. The woman with whom she lives said she'd been in Beddard-ly a week. You see she's French (and mine is about as limited as that of another surgeon I've met who speaks of 'kidney-gauche'—of course, it would be Rudolph me to mention names)—consequently, we can't Todd-le very quickly. Even her own Scotch doctor said he could 'McNair-thing oot of her.' Hughes to let her have Mutch of her own way. But on the whole she's feeling a little better this afternoon, although she looks White, and occasionally her side still Hertz. But what can you expect when she will Rowland squirm about. She's had no previous illnesses, only measles, and a bite from a Colley when about 12 years old."

Physician: "Thinking of operating?"

Clinical: "No. I think I shall Turner out and send her to the Theatres on Saturday Ormond-ay, via Martha—that short circuitous route we know so well. It's Saner than doing it here."

Physician: "Why don't you have a shot at operating?"

Clinical: "Too much Fagge this week, and you can't Fawcett, besides, she'll be more satisfactorily Dunn upstairs; they'll Hunt the mystery out there better. If she can be cured I'm Shaw she'll Layton-s of thanks at our feet."

Physician: "By George! Poor Martha comes in for everything, it's a Pitt-y we can't do it here. Yes, it's a long Lane that has no circuit."

Appointments.

Medical School Appointments.

JANUARY—MARCH, 1914.

Clinical Assistants.—Messrs. W. E. Tanner, F. V. Bevan-Brown, J. F. Venables, C. Sherris, P. H. Berry, E. W. Blake.

Clinical Assistants in Medical Wards.—Messrs. A. S. Erulkar, C. H. L. Harper (Dr. Hale White); L. Muir-Smith, F. Gilbert L. Scott (Sir Cooper Perry); H. P. Whitworth, A. N. Minns (Dr. Shaw); H. L. P. Peregrine, F. H. Dodd (Dr. Fawcett).

Clinical Assistants in Surgical Wards.—Messrs. F. Tooth (Mr. Dunn); W. D. Galloway (Sir Alfred Fripp).

Dressers in Special Departments:—

Throat and Ear, Children, Genito-Urinary.—Messrs. R. W. P. Jackson, A. K. Day-Lewis, L. S. Fry, A. J. Drew, T. A. Townsend, C. Dean, C. H. Medlock.

Throat and Ear, Skin, Orthopædic.—Messrs. J. F. H. Stallman, R. Quesada, N. H. W. Saw, F. W. Lawson F. C. S. Broome, H. S. Groves.

Eye, Nervous System.—Messrs. H. F. T. Hogben, W. L. E. Reynolds, H. Q. F. Thompson (Mr. Eason); F. E. Laborda, B. Burnside, D. C. Scott, H. H. Elliot D. M. McManus (Mr. Ormond).

Obstetric Dressers and Externs.—Messrs. J. H. Parry, W. A. Young, L. A. J. Graham, J. E. Davies, W. H. Nicholls, L. R. Pickett, A. L. Anthony (Mr. Bellingham Smith); A. H. Harkness, O. G. Parry-Jones, C. E. Petley, L. Horsley, S. A. Liebson, J. Stephenson, C. de W. Gibb (Mr. Chapple).

Surgeons' Dressers.—Messrs. R. A. Holmes, R. Curle, K. L. Bates, G. B. Tarring (Sir W. Arbuthnot Lane); E. W. Bowell, W. A. Easton, S. W. Coffin, M. Chadwick. W. L. Partridge (Mr. Dunn); C. C. G. Gibson, A. C. M, Coxon, B. Sampson, G. D. Gripper (Sir Alfred Fripp); C. P. Symonds, L. R. Broster, E. J. Cooke, N. E. Kendall, A. F. Rook (Mr. Steward).

Medical Ward Clerks and Post-mortem Clerks.—Messrs. C. W. Baxter, J. G. Stevens (Dr. Hale White); A. L. Punch, J. Kyle (Sir Cooper Perry); M. J. T. Wallis (Dr. Shaw); V. E. Lloyd, G. S. B. Long (Dr. Fawcett). E. S. Bowes, L. P. Waghorn, J. F. Carter-Braine, A. H. Cocking, A. D. Marston, M. Pearson, A. F. G. Guinness, E. M. Litchfield, J. B. Fairclough, R. S. Craig, A. Traill, D. M. Whitcombe, E. C. Morgan.

Assistant Surgeons' Dressers.—Messrs. J. J. Conybeare, F. A. Knott (Mr. Fagge); K. N. Purkis, J. G. Jones, C. H. Edwards, (Mr. Rowlands); E. Biddle, L. H. S, Evans (Mr. Turner); V. R. Hirsch, D. H. A. Galbraith (Mr. Hughes); G. Noott, M. Pearson (Mr. Davies-Colley).

Surgical Ward Clerks.—Messrs. P. G. McEvedy.

Pathological Assistants to Demonstrators of Morbid Anatomy.—Messrs. W. A. Young and G. L. Attwater.

Student Demonstrator of Anatomy.—Mr. C. S. Lane Roberts.

Civil.

Hildred B. Carlill, M.D., B.C., has been re-appointed Clinical Assistant at the West End Hospital for Diseases of the Nervous System.

[CORRECTION.—We regret that a mistake occurred in our last issue under "Appointments." Mr. P. C. P. Ingram has been appointed to the Royal Gwent Hospital, Newport, Monmouthshire, *not* the Royal Government Hospital, as printed.]

Metropolitan Asylums Board.

Instruction in Fevers.

JANUARY CLASSES, 1914.

A Course of Instruction in the Diagnosis and Treatment of Fevers will be held at each of the undermentioned Hospitals on the days and at the times stated below. N.B.—Attendance may be commenced during the second month of a course.

Eastern Hospital, Homerton Grove, Homerton, N.E. E. W. Goodall, M.D., Medical Superintendent. Monday and Thursday morning at 11, beginning 5th January.

North-Eastern Hospital, St. Ann's Road, Tottenham, N. F. H. Thompson, M.B., Medical Superintendent. Monday and Thursday morning at 11, beginning 5th January.

North-Western Hospital, Lawn Road, Hampstead, N.W. J. MacCombie, M.D., Medical Superintendent. Tuesday and Friday at 2 p.m., beginning 6th January.

Western Hospital, Seagrave Road, Fulham, S.W. R. M. Bruce, M.R.C.S., Medical Superintendent. Tuesday and Friday at 2 p.m., beginning 6th January.

South-Western Hospital, Landor Road, Stockwell, S.W. F. Foord Caiger, M.D., Medical Superintendent. Tuesday and Friday at 2 p.m., beginning 6th January.

Grove Hospital, Tooting Grove, Tooting Graveney, S.W. J. E. Beggs, M.D., Medical Superintendent. Wednesday at 2.30 p.m., and Saturday morning at 11, beginning 7th January.

Brook Hospital, Shooters Hill, Woolwich. J. B. Byles, M.B., Medical Superintendent. Monday and Thursday at 2.15 p.m., beginning 5th January.

The succeeding Course will commence in May, 1914.

Nov., 1913. By Order,

T. DUNCOMBE MANN,
Clerk to the Board.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette." Guy's Hospital, London, S.E.*

Guy's Hospital Dental Society.

THE Dental Society is certainly in a very flourishing condition. Men turn up to its meetings as well as to its teas. They not only listen to papers, but some are even moved to comment on them. Some, in fact, are so ready to give people the benefit of their profound wisdom and experience that they get on their legs as often as they find the benches unnecessarily hard.

It is a fact that Class Room No. 2 is hardly in keeping with the character and requirements of the society. It is far too small, and as a consequence men are uncomfortably cramped; ventilation is hopeless, and the resultant fog from a hundred pipes is the reverse of stimulating. Moreover, all these factors tend to restrain that delightful feeling of informality which should characterize the procedure of every students' meeting.

However, men are so perverse that some actually seem to enjoy the experience of an opium den for once in a way, and certainly the attendance does not appear to suffer.

Mr. Underwood, who, in company with certain others, is greatly missed as a speaker, very sportingly doffed his tall hat and came along to delight his audience as a writer of an extremely controversial paper.

The subject "Bands" offers endless possibilities. Frankly with our knowledge of the professor as a humorist we were disappointed that he did not make more of it.

We suppose that Bands cause more annoyance at this time of year than anything else. Certain is it, that in season and out of season, they form the bed-rock on which half the members of the profession split. A man who has the courage to condemn them is promptly told that he is incompetent. If he support his contention, from a medical point of view, and enlarges on the possibilities of secondary complications, he is told that he is a visualist, a dreamer, a fanatic, anything in fact, but that "end all and be all of so many men of this generation," a practical man.

Happily there are extremists of two kinds, one the contemptuous dogmatist, the other the persuasive controversialist, who delights to sharpen his wits by taking up a standpoint which invites discussion. Underwood naturally belongs to the latter class. His paper contained many sweeping assertions, but his voice and manner were honeyed in the extreme. He literally sandwiched the pill with the jam, and the mixture, if we may continue the metaphor, was infinitely pleasing.

As a natural consequence the debate which ensued was of a quiet, nay almost academic, character.

Laver did not speak, but most other people of the same calibre did, the list including—but we fear to offend the individual by placing all in the same category.

Millett and Bulleid had little to say but said it; the former with more hesitancy than when he plays at H.O.P.; the latter with his usual amiability. Messrs. Clewer and Lowein related interesting experiences.

Mr. Viljoen saved the reputation of the society by thanking the reader for his paper in a very courteous and characteristically modest speech.

We regret to chronicle the fact that Haine went to sleep, while Saul was equally inactive. Crook smiled seraphically and related a case. Mr. Smale said something in a high-pitched voice, but it did not catch our ear, while subsequently Mr. Doubleday monopolized all our attention.

Finally the meeting adjourned with a cordial vote of thanks to the chairman.

The Neuro-Muscular Mechanism of the Larynx.

A Laryngological Demonstration.

BY T. B. LAYTON.

The muscles of the larynx may be classified as being abductors and adductors of the vocal cords and those concerned with tension of the cords. With the last, which are purely muscles of vocalisation, we are not concerned to-day, The adductors also are muscles of vocalisation, but, in addition, are protective to the respiratory tract by preventing foreign bodies passing down. The abductors are purely respiratory muscles.

These abductors are a single pair of muscles, the crico-arytenoidei postici, while the adductors are the paired crico-arytenoidei laterales and the unpaired arytenoideus.

When the cords are examined post-mortem they are seen to lie mid-way between abduction and adduction and to be concave inwards. This, then, is the position the larynx takes up when no muscles are acting on it and is known as the cadaveric position.

During life, in quiet respiration, the glottis is two or three times as large as it is in the cadaveric position. This is not merely a statement of observation, for the accounts of older observers were not all in agreement. It has been put to the experimental test by Sir Felix—then Dr.—Semon.[1]

Sir Felix measured the width of a number of larynges post-mortem between the arytenoid processes, and he did the same by means of a graduated mirror in persons who had been taught to breathe quietly while a laryngoscopic examination was being made. As a result of this he found that "during quiet respiration the width of the glottis in both cases is . . . . . in reality twice and a half to nearly three times that size" which it is after death, and that "under all circumstances the minima as observed during life are greater than the maxima seen after death."

This position of quiet respiration is then the second main position of the glottis. The third is that of deep inspiration in which the cords are more widely dilated and the area of the glottis greatly increased.

The fourth position of the larynx is that of phonation in which both cords are approximated in the mid-line and the area of the glottis reduced to a minimum or rendered non-existent.

The passage from the cadaveric position to the last two is an active movement caused on abduction by the crico-arytenoideus posticus and on adduction by the laterales and arytenoideus. The determination of the actions of these muscles has not merely been deduced from the positions of their attachments; they have also been observed during life by Risien Russell and after death by Semon and Horsley.

Risien Russell[2] found that he could, in the living dog, divide up the recurrent laryngeal nerve into bundles of fibres which were physiologically distinct, so that when he stimulated one bundle adduction of the larynx occurred, but when another, abduction. He observed that during abduction the muscle which contracted was the crico-arytenoideus posticus, and after death he traced to this muscle the fibres, by stimulation of which, he had got abduction. There is then no doubt as to the action of this muscle. Semon and Horsley[3] directly stimulated the muscles of the larynx excised immediately after death, and, although the experiment was done for another purpose which we must consider later, their observations coincided with the view generally accepted as to the functions of these muscles.

In the human larynx the recurrent laryngeal nerve passes under the lower margin of the inferior constrictor muscle, through its attachment to the cricoid, and then divides just behind the crico-thyroid joint, one branch passing mesially to the crico-arytenoideus posticus, the other continuing upwards and forwards over the joint to the adductors and thyro-arytenoid. Just after its point of entry there the nerve lies in the submucous tissue of the hypo-pharynx just where this is becoming œsophagus. Before its entry it lies just behind the thyroid body at the posterior margin of the lateral lobe. Other important relations after it leaves the vagus vary on the two sides, on the left it is in relation with the œsophagus for an appreciable distance and winds round the aorta just lateral to the ligamentum arteriosum where also it lies above the left auricle; on the right it winds around the subclavian artery; on either side it is in relation with the cellular tissue of the neck and mediastinum, but owing to its longer course the left is in relation to more of this tissue.

The fibres to these muscles pass from the medulla to the origin of the recurrent nerve in the vagus nerve and therefore pierce the dura mater and the skull through the jugular foramen.

In the vagus the fibres to the larynx arise in the nucleus ambiguus, and represent the lateral somatic efferent fibres of a typical segmental spinal nerve.

This nucleus is a column of cells which lies in the reticular formation of the medulla ventral to the principal mass of grey matter which lies beneath the floor of the fourth ventricle and dorsal to the olivary nucleus. Elliott Smith[4] looks upon them as cells supplying the branchial musculature detached from the homologue of the ventral horn. Kosaka[5] has subdivided the nucleus into three parts: an upper, middle, and lower. The upper supplies the motor supply of the pharynx, crico-thyroid, and part of the œsophagus; the middle gives off the fibres to the palate; while the lower may again be subdivided into two, the medial part giving off the fibres of the recurrent laryngeal nerve and the lateral the fibres of the inhibitory nerve of the head. If this view is correct, the nucleus

contains splanchnic efferents in addition to the somatic efferents to the branchial musculature.

So much for the lower neurones; to consider the upper neurones it is best to begin in the cortex and trace them downwards. Semon and Horsley[6] investigated this in the monkey, dog, and cat. In macacus sinicus a focus was found at the lower end of the pre-central gyrus, at the most anterior end of which only the cords moved; behind this part movements of the cords were found combined with pharyngeal movements. The movements were invariably adduction and perfectly bilateral. Beyond this focus over the whole facial area they obtained, concomitant with the movements of the face, a slight degree of adduction, as far as the cadaveric position. In the dog similar results were got, but in neither of these animals could they find abduction represented in the cortex; in the cat, however, abduction associated with other movements was found to be represented. When they passed from the cortex to the internal capsule the following were found from before back in all the animals, just in front of the genu acceleration of respiratory movements, and at the hinder end of this area abduction was associated with the other movements; just behind the genu mixed movements or diminution of abduction; and over a very small area in the posterior limb pure adduction was got. In the cat alone pure abduction was found. Again all the movements were bilateral. Lastly, they turned to the bulb, by stimulating the floor of the fourth ventricle the following were found:—bilateral abduction, bilateral incomplete abduction, or confusion of movements, and bilateral adduction; also over a small area unilateral abduction was obtained, but they were not certain whether this could be attributed to the stimulation of the nerve centres or of the fibres as they passed through the medulla to the superficial origin of the vagus nerve.

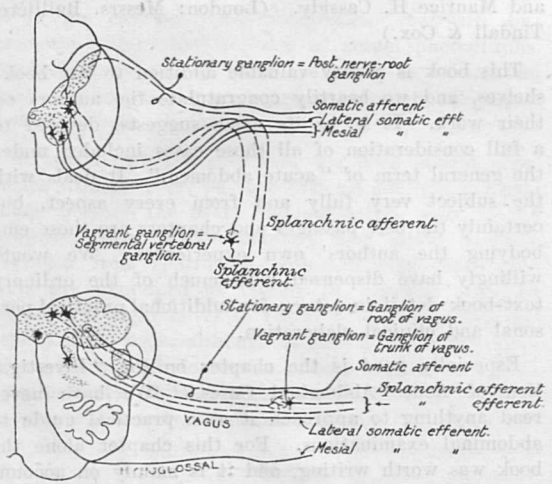
Risien Russell[7] found, however, evidence of an abductor cortical centre in other animals, though with greater difficulty than in the cat. He first got evidence of it when examining the cortex after he had divided the adductor fibres of one recurrent nerve, but later, when experience had told him where to look for it, he sometimes found it with the nerve intact. Like the adductor centre he found this on either side to be bilateral in its action. He points out that his results are not incompatible with those of Semon and Horsley, if we remember that the latter only experimented with the intact nerve, and that in all animals they found evidence of abduction when the internal capsule was stimulated.

We see then that in each cortex is a focus governing adduction in all animals, and possibly in all animals one governing abduction; but that this last movement is much less represented in the cortex than is the former.

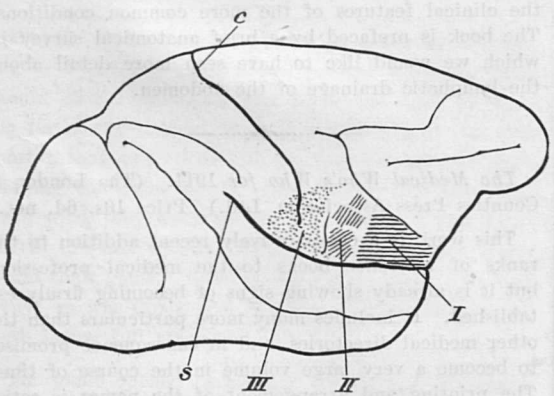
Sherrington[8] has grouped the movements elicitable from symmetrical areas of the cortex into allied, antagonistic, neutral, and bilateral. In the first, the movement evolved from one cortex seems a fraction of a natural movement, which for its completion needs also a stimulus from the corresponding part of the other cortex. He gives as an example of this the closure of the jaw; elevation of the eyes is another that comes to the mind. In the second type a focus of one side of the cortex is inhibited by its corresponding area on the other cortex, and of such is the conjugate deviation of the eyes to the right and left. The neutral actions are those such as the movements of the limbs where stimulation of one cortex has no effect at all on the musculature controlled by the corresponding area of the other cortex. There remains a few movements which are strictly bilateral, that is, they can be evolved equally well from either cortex. Beavor and Horsley[9] found the only movements which are purely bilateral to be those of the larynx, of pursing of the lips, of swallowing, and of mastication, and Sherrington would remove this last into the class of allied actions.

All the movements of the larynx are certainly bilateral. Risien Russell[7] quotes an Italian, Masini, as having claimed to have obtained some evidence of unilateral action, but the investigations already mentioned, as well as those of Mott[10] are uniformly against any such. This bilateral movement is not controlled by the corpus callosum since it is still obtainable by stimulation of the internal capsule and the

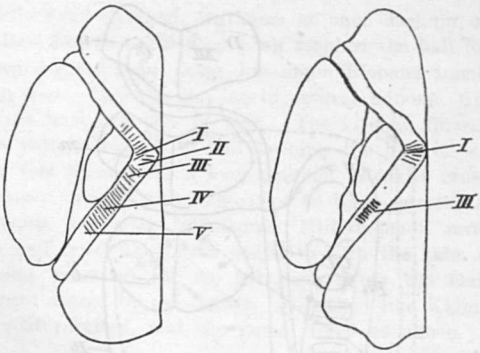
medulla, and Mott found it could still be got equally well from either cortex after the corpus callosum had been divided. It must, therefore, be somewhere down in the medulla that this action is effected, and Cajal[11] has found that some of the fibres of the nucleus ambiguus pass across into the other side of the medulla.



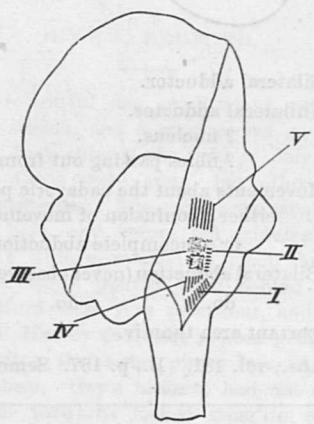
I.—Quain's Anatomy, vol. iii., part ii., figs. 74-75.
G. D. Thane based on Gaskell.



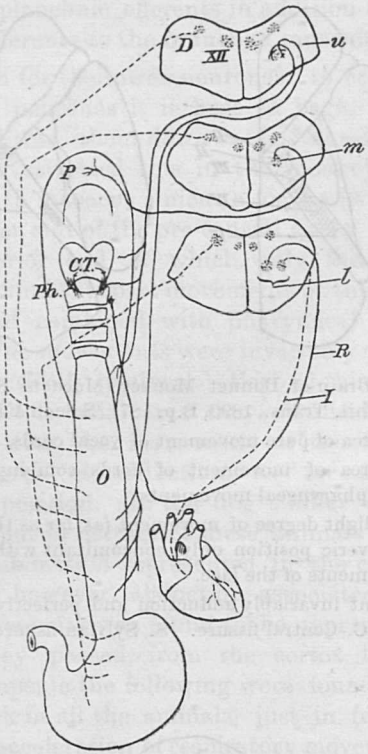
II.—D. Dorsal nucleus of vagus.
xii. Hypoglossal nucleus.
u. Upper
m. Middle
l. Lower
} Parts of nucleus ambiguus.
R. Recurrent Laryngeal. I. Inhibitory cardiac fibres.
P. Palate. Ph. Pharynx. C-T. Crico-thyroid.
O. Œsophagus.
Kosaka. Neurolog. Central., vol. 28, p. 409.



III.—Brain of Bonnet Monkey (Macacus Sinicus).
Phil. Trans., 1890, B.p. 187. Semon & Horsley.
i. Area of pure movement of vocal cords.
ii. Area of movement of cords combined with pharyngeal movements.
iii. Slight degree of movement (as far as the cadaveric position only) concomitant with movements of the face.
Movement invariably adduction and perfectly bilateral.
C. Central fissure. S. Sylvian fissure.



IV.—The Bonnet Monkey (Macacus Sinicus).
Area of capsule over which some response was got.
(*a*) i. Acceleration of respiration.
ii. Abduction.
iii. Mixed movements or diminution of abduction.
iv. Adduction.
v. Diminution of abduction.
Localisation of important points.
(*b*) i. Acceleration of respiration.
iii. Mixed movements or diminution of abduction.
All movements completely bilateral.
Based on Semon and Horsley.



V.—i. Bilateral adductor.
ii. Unilateral adductor.
? nucleus.
? fibres passing out from it.
iii. Movements about the cadaveric position.
either = confusion of movements.
or = incomplete abduction.
iv. Bilateral abduction (never observed unilateral).
v. do. do.
More important area than iv.

Phil. Trans., vol. 181. B., p. 187. Semon & Horsley.

[1] Proc. Roy. Soc., vol. 48, p. 415.
[2] Proc. Roy. Soc., vol. 51., p. 102.
[3] B.M.J., 1886, vol. 2, p. 405.
[4] At the Anat. Soc. of Gt. Britain and Ireland, Nov., 1912.
[5] "Neurolog. Centralb.," Vol. xxviii., p. 406.
[6] Phil. Trans., 181, B., p, 187.
[7] Phil. Trans., 187, B., p. 59.
[8] Integrative action of the nervous system, p. 289.
[9] Beavor and Horsley, Phil. Trans., 181, B., p. 128.
[10] B.M.J., 1890, vol. I., p. 1124.
[11] Quoted in Quain's Anat., vol. iii., pt. 1, p. 135.

Reviews, etc.

Books for review should be addressed to The Editor, Gazette Office, Guy's Hospital, S.E. Their price should in every case be stated.

Acute Abdominal Diseases. By Joseph E. Adams and Maurice H. Cassidy. (London: Messrs. Baillière, Tindall & Cox.)

This book is a very valuable addition to our bookshelves, and we heartily congratulate the authors on their work. It is, as its name suggests, devoted to a full consideration of all those cases included under the general term of "acute abdomen." It deals with the subject very fully and from every aspect, but certainly the best passages and chapters are those embodying the authors' own experiences. We would willingly have dispensed with much of the ordinary text-book detail in return for additional practical personal and clinical elaboration.

Especially good is the chapter on the "Investigation of Acute Abdominal Cases." We have never read anything to approach it as a practical guide to abdominal examinations. For this chapter alone the book was worth writing, and it is mainly on account of it that we think the book is one to be read by recently qualified men, especially those who are doing house-appointments and are frequently coming in contact with obscure or doubtful abdominal cases. Of the rest of the book we were especially pleased with the section on Intussusception and the descriptions of the clinical features of the more common conditions. The book is prefaced by a brief anatomical survey in which we would like to have seen more detail about the lymphatic drainage of the abdomen.

The Medical Who's Who for 1914. (The London & Counties Press Association, Ltd.) Price 10s. 6d. net.

This work is a comparatively recent addition to the ranks of reference books to the medical profession, but it is already showing signs of becoming firmly established. It includes many more particulars than the other medical directories, and in consequence promises to become a very large volume in the course of time. The printing and arrangement of the names is satisfactory, as is also the general appearance of the book.

The Students' Handbook of Gynæcology. By Drs. G. H. Herman and R. Drummond Maxwell. Second edition.

This small volume is intended to represent a condensed edition of Dr. Herman's Diseases of Women, and as such should certainly be a great help to stu-

dents for purposes of revision, as it contains all the essential teaching of Dr. Herman's larger volume, which is clearly and sometimes of necessity dogmatically explained.

A feature in which it differs from most cram books is the illustrations, which are aptly chosen and are of great assistance in helping readers to follow and remember the authors' arguments. Especially is this so in the case of those illustrations that are diagramatic rather than reprints of actual photographs. About half a dozen of them are plates in colour, and these are certainly good representations of the actual disease as seen clinically.

It seems rather a pity that the book should commence with chapters on such difficult subjects as headaches, pain in the back, and abdominal pain, as the student reading these chapters first might be discouraged from continuing, although even these subjects are explained as clearly as possible. On the whole, one ought never to regret having read this excellent little book, although it should be looked upon purely as a book for revision, and should, under no circumstances, replace larger text-books in a student's library, but merely supplement them.

Rugby Football.

GUY'S v. RICHMOND.

Played on the Hospital ground on Saturday, December 6. There was a fine crowd present when the game should have commenced, but Richmond kept us waiting for nearly half an hour, and then played one man short throughout. This did not, however, prevent them winning the game by 11 points to 3. By hard forward work they went for the line from the first kick-off till the last whistle, and our forwards never really found their game. Roberts and Parry-Jones were both away; so was Curle and Broster. Our opponents also were below full strength.

The game opened favourably for us, and Mackenzie made a good run from a neat pass, but the hard footwork of the Richmond men soon put us on the defensive. It was, however, from an attacking movement by our backs that Richmond scored. Harkness threw back, but a little wide of his man, and Gilliard, the visiting right outside, got his foot to the ball, and, going on, scored wide out. Gilliard then put in a neat run on his own, and handed in to Goodman, who sent Gardner in for the next try, Bloomer converting.

Ends were changed, Harkness at once dashing over the line, but the defending back reached the ball first. Tweed did the same thing, but again Bloomer touched down first. This was the last of several minors. Guy's did not have the best of luck. The visiting forwards were still on top of us and keeping the ball close to their feet throughout a long dribble. Reckitt crossed to score. Millett had now come to three-quarter and Harkness had gone full back. Millett made several runs and tried hard with Steyn to turn the tide, but nothing came off for us, till just before the end a forward scored by the corner. It looked like Kidman. No goal resulted, and the game ended as above.

GUY'S.—H. Millett, (back); M. Mackenzie, S. S. L. Steyn, A. H. Harkness, A. F. Rook (three-quarters); M. S. Hopson, C. H. Medlock (halves); M. Tweed, C. H. Laver, A. S. Liebson, E. F. Llarena, A. B. Danby, A. L. Anthony, G. F. Kidman, A. M. Munday (forwards).

REMARKS.—It was a game lost simply because our forwards had an off day; Laver, Kidman, and Anthony were the best. The backs had few chances behind a pack somewhat bustled, but their defence was not good by any means. The tackling was fair, but the ground defence not at all up to Guy's standard.

GUY'S v. BEDFORD.

It was a delightful day at Bedford on December 13th for this match, and a good crowd gave the side a welcome as they entered the field of play. Roberts, Broster, and Curle were away, but otherwise Guy's were well represented. The game soon went in favour of the home side, and before ten minutes' play had gone by Guy's were compelled to touch down in defence. Again Guy's punted from behind their goal line, but Bedford were very persistent, and the attack ended with A. Harvey dropping a good goal for them. Very soon after the same player almost landed a penalty for them. Guy's hitherto had not done much attacking; the forwards lacked sting in their work, and Bedford, keeping up the pressure, Gillam scored an unconverted try, followed by another one for Bedford, this being gained by Harvey. Rook received from a cross kick by the opposition, and gave up to Parry-Jones who gained a try.

After half-time Bedford went still further ahead, Maxey and Carter getting over for them, but neither try was added to. Guy's now had more of the play, but nothing was scored for them till about 15 minutes from the end when Parry-Jones got a try for Medlock to convert. Medlock also had very hard luck in not goaling from a penalty. This was all the scoring, the final being, Bedford, 1 dropped goal 4 tries, 16 points; Guy's, 1 goal 1 try, 8 points.

GUY'S.—A. H. Harkness (back); S. S. L. Steyn, C. H. Medlock, H. Millett, A. F. Rook (three-quarters); M. Hopson, L. C. Broome (halves); O. Parry-Jones, M. Tweed, E. F. Llarena, A. L. Anthony, C. H. Laver, G. F. Kidman, A. B. Danby, A. S. Liebson (forwards).

UNITED HOSPITALS (LONDON) v. UNITED HOSPITALS (DUBLIN).

It was a very hard game at Richmond between these sides on Wednesday, December 10th. The Irish had a fine team, including six internationals. They fairly beat the London men by no less a margin than 21 points to 3. It was a pity, though it must not be advanced as an excuse, that the home side could not field a full side. Watson of London, Williams of Bart.'s, Roberts of Guy's, Macafee of London, and Smythe of Westminster were not able to get off, or were on the injured list. At centre and forward we were outplayed. The visitors played a tremendous game forward, and never gave the home side time to breathe. It was "feet" the whole time, and be it added "feet" with a vengeance. Steyn got a try quite early, but this was all London's scoring. After Quinn added a try for the visitors and Gregg had converted, Broster got a nasty kick above the eye, and had to retire permanently. This was bad luck indeed. Millett came up to scrum-half, and Hartgill went full-back. Before half-time Wood got over the line, but no goal resulted. London looked like pulling up the points after change of ends, but the effort died away, and the weakened pack gradually were compelled to give ground to the untiring eight opposed to them. Tries were gained by Quinn, O'Connell and Stokes, Gregg converting two of the kicks. The total score was Dublin, 3 goals 2 tries, 21 points; London, 1 try, 3 points. Team :—

UNITED HOSPITALS.—H. Millett (Guy's) (back); S. S. L. Steyn (Guy's), J. Evans (Middlesex), R. V. Hudson (Middlesex), W. A. Stewart (London) (three-quarters); C. H. Medlock (Guy's), L. R. Broster (Guy's) (halves); L. G. Brown (London), J. B. Mudge (Bart.'s), C. H. Laver (Guy's), E. Van-Dyck (Middlesex), A. B. Rosher (Charing Cross), H. L. G. Hughes (University Coll.), W. C. Hartgill (London), L. B. Lapage (Middlesex) (forwards).

We very much regret that we have been unavoidably compelled to hold over the account of the Meeting of the Physical Society dealing with the Treatment of Syphilis.

Change of Address.

Hildred B. Carlill, M.A., M.D., M.R.C.P., 14, Harley Street, W. (*Teleph.* 88 Mayfair), and 89, North Gate, Regent's Park, N.W. (*Teleph.* 6300 Hampstead).

Dr. F. E. Shipway, from 24A, Portland Place, W., to 61, Queen Anne Street, W. (*Teleph.* 3841 Mayfair).

H. C. Lucey, M.D., B.S., to 26, St. Thomas's Street, S.E.

Mr. Ralph Thompson's telephone number is Mayfair 3600, and not as stated in the "Medical Directory."

Christmas Ward Concerts.

The Ward Concerts are arranged as follows:—

Friday, December 26th.—Esther.

Saturday, December 27th.—Lydia. Luke. Addison.

Monday, December 29th.—Charity. Dorcas. Mary. Bright.

Tuesday, December 30th.—Job. Naaman. Eye. Stephen. Cornelius.

Wednesday, December 31st.—Patience and Samaritan. Astley Cooper.

Births.

HODGSON.—On October 14th, 1913, at Dulwich Hill, Sydney, New South Wales, the wife of C. R. Hodgson, M.D. Lond., of a daughter.

Marriages.

GARDNER—PULLEIN-THOMPSON.—On December 11th, at Christ Church, Chelsea, by the Right Revd. the Lord Bishop of London, assisted by the Revd. Canon Cooper Marsden and the Revd. T. A. Hanson, Alfred Linton Gardner, M.R.C.S., L.R.C.P., son of Mr. J. T. Gardner, M.R.C.S., of 276, Earl's Court Road, to Emily Muriel, daughter of the Revd. J. Pullein-Thompson, Vicar of Christ Church, Chelsea.

TICEHURST—CROSS.—On December 8th, at the Church of St. Alfege, Greenwich, Norman Frederic Ticehurst, M.A., M.B., B.C. Cantab., F.R.C.S. Eng., to Ivy, the second daughter of Henry Cross, of Greenwich.

Deaths.

WILLIAMS.—On the 7th inst., at his residence, 5, Amhurst Park, London, N., Henry Williams, Clerk of Guy's Hospital, second son of the late Revd. David Williams, formerly Fellow of New College, Oxford, and Rector of Alton Barnes, Wilts., in his 70th year.

WINGENT.—On December 14, Ralph M. Wingent, youngest son of Frederick and Eliza Wingent, of Castle Gardens, Rochester, in his 36th year.

G. T. M.